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MEDICAL CONSTRUCTION AUTHORIZATION REQUEST OF THE VETERANS' ADMINISTRATION

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE-HUNDREDTH CONGRESS

FIRST SESSION

WEDNESDAY, MARCH 11, 1987

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MEDICAL CONSTRUCTION AUTHORIZATION REQUEST OF THE VETERANS' ADMINISTRATION

WEDNESDAY, MARCH 11, 1987

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. Tim Penny, presiding.

Present: Representatives Montgomery, Penny, Staggers, Rowland of Georgia, Bryant, Florio, Kanjorski, Stenholm, Kennedy, Hammerschmidt, Smith of New Jersey, Stump, Bilirakis, and Rowland of Connecticut.

OPENING STATEMENT OF HON. TIMOTHY J. PENNY

Mr. Penny. (presiding.) The committee will come to order.

The topic of the hearing today is the medical construction authorization request of the VA. The VA has requested for fiscal year 1988 $525.7 million for the agency's construction program. Of that amount, $394 million is for the medical care major construction program and $121 million for minor construction. Before each member is a list of the specific projects which are included in the proposed VA budget.

The most important aspect of the construction program is its impact on the future ability of the VA to deliver health care.

The decisions made during this session of Congress will set the capacity limits for medical care in various locations around the country for many years to come.

In order for our committee to do its job and, it seems to me, in order for the VA to do its job for the future of VA health care, there must be planning for construction. The Congress has mandated two distinct requirements. One is a 5-year plan for construction, replacement, or alteration of medical facilities, and the other is a 5-year strategic plan regarding missions of VA facilities.

These two reports were due in June of 1986. We received them only 2 days ago. That is fully 9 months late. I wish these documents had been available when we considered our budget recommendation last month. Hopefully, the VA will be more responsive next year.

We have nine Members of Congress who wish to testify today. The first is the Honorable Jim Florio, who is a member of our full committee.

Before I recognize Jim, I want to announce that the chairman, Mr. Montgomery, just stepped in the door.

Mr. MONTGOMERY. Mr. Chairman, you started on time, so you stay right there. Thank you very much.

Mr. PENNY. I will now call on the Honorable John Paul Hammerschmidt for any opening remarks he may have.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Chairman.

This morning's hearing concerns a major element of the fiscal year 1988 VA budget—construction. We appropriately hear this part of the budget request separately because of its importance to the VA's future and because of its size and complexity, because without adequate facilities, services to veterans cannot be adequate. Following the example of Chairman Montgomery, I know that every member of this subcommittee and of the whole committee is strongly committed to a viable VA construction program compatible with the state of the art.

We simply cannot allow the VA's hospitals and other buildings to become functionally obsolete. To allow that to happen would be to allow the VA itself to die of old age. I am pleased that this construction budget request of $525.7 million appears to be generally adequate while being fiscally responsible. It includes 15 major projects and would, among other things, fund construction for replacement facilities at Dayton, Ohio and North Chicago, Ill., and for colocation of the Wichita regional office with the medical center.

However, Mr. Chairman, with unanimous support, we have already addressed in the full committee's recommendations to the Budget Committee some areas of needed enhancement in the VA construction budget. For example, there was no money in that budget for new VA nursing homes. Yet, this is an area in which demand is growing the fastest, and it will continue to grow until after the turn of the century. Reliance on State and private nursing homes to a significant extent will be unavoidable because it is obvious that enough VA nursing home capacity cannot be created to carry the whole load. What must be avoided, though, is a wholesale shift to State and private nursing homes. This must be avoided for three basic reasons.

First, and most importantly, this is a Federal responsibility and it will always be a Federal responsibility. Second, a loss of control over quality of care for veterans must be avoided. And third, the capacity of State and private nursing homes to care for the number of veterans needing nursing care is in considerable question.

Therefore, we have recommended the following for additional VA nursing home care units: $6 million for Tampa, FL; $6.5 million for Mountain Home, TN; and $4.1 million for Wilkes-Barre, PA. In addition, we have recommended $1.5 million in design funds for the proposed nursing home care unit at Palm Beach, FL. The other important construction budget enhancement we have recommended is $14.3 million in design funds for a needed clinical addition project in Dallas, TX.

Mr. Chairman, the long-range planning process for VA construction has received its share of criticism in the recent past, and I believe the criticism has been generally constructive. An effective planning process is critical for cost efficiency and for placement and replacement of facilities where they will do the most good. We will want to hear more about the VA's efforts along these lines.

Finally, Mr. Chairman, I want to join you in welcoming a number of our colleagues who will testify on the proposed construction budget. Chris Smith, Jim Florio, and Jim Howard of New Jersey, Richard Ray of Georgia, Dave McCurdy of Oklahoma, Nick Rahall of West Virginia, Charlie Bennett of Florida, Pat Swindall of Georgia, and Dan Glickman of Kansas will all share with us their views this morning. What they have to say deserves and, of course, will receive our most serious attention.

Thank you, Mr. Chairman.

Mr. PENNY. Thank you, John Paul.

Congressmen Marvin Leath and Martin Frost of Texas, Doug Walgren of Pennsylvania, and Tony Hall of Ohio were all unable to join us this morning but have submitted statements for the hearing record. In addition, the Blinded Veterans Association has also submitted a statement for inclusion in the hearing record. And Chairman Montgomery has additional remarks that he would like included in the record. Without objection, be so ordered.

With that, we want to first recognize the Honorable James Florio, a member of our committee.

Dr. ROWLAND OF GEORGIA. Mr. Chairman, before the witnesses are recognized, I have a statement that I would like to read, a very short statement.

Mr. PENNY. Without objection, the Chair would recognize Dr. Rowland.

OPENING STATEMENT OF HON. J. ROY ROWLAND

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman.

I also want to welcome our colleagues, Chris Smith and Jim Florio, Charlie Bennett, Richard Ray and the others that will be coming.

I don't suppose there are many subjects that are much drier than the bricks and mortar of medical facilities, and yet there are few subjects that are more important by the veterans in terms of the quality of health care that they receive. I guess when the subject gets tough is when we talk about the money that is really involved.

The VA has requested for fiscal year 1988 $394 million in medical care construction. How those funds are spent is the responsibility of the VA, and it is clearly the responsibility of us, as Members of Congress. That is why I was so disappointed to miss an early opportunity to read the 5-year projections presented to the committee only just 2 days ago. It is obvious that the future needs can be accurately assessed only when as much information can be presented. The timely submission of the required documentation is critical to us.

Two issues stand out for me. First, the number and location of nursing home beds is very important. I'm interested in the details of how the VA intends to supplement its request for only one nursing home care unit in the next 5 years with State veterans homes and community nursing homes. And second, the need for additional outpatient clinic capacity. As we will note from the testimony of our colleagues this morning, the strains on clinics currently in operation are growing steadily, and I just want to understand the VA's strategy with respect to this situation. The need is really evident and I hope that we can all work together in addressing it, Mr. Chairman.

I will have some questions about these programs later on. Thank you for allowing me to read this statement.

Mr. **Penny.** Are there further statements for the record by any members of the committee? If not, we will proceed with those members who have asked to formally testify this morning. I might invite the others who are here to just come to the table and take their turn down the line.

First, though, we want to call on James Florio.

STATEMENT OF HON. JAMES J. FLORIO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. **Florio.** Thank you very much, Mr. Chairman.

In the interest of conserving the committee's time, I have a formal statement that I would like to put into the record. I would like to summarize the essence of my message, which I suspect the chairman of the committee, as well as other members, are getting tired of hearing, because I have been trying to convey this message to the committee for the last number of years. Of course, it deals with the problem we have in the southern portion of my State, with the inadequacy of health care opportunities that are available to veterans.

To make a long, sad history very short, in 1980 this Congress authorized and appropriated some $60 million for a full VA hospital to be located in the city of Camden. The money was authorized; the homes were acquired; people were moved off the site; ground was broken and contracts were let. Then the new administration came in and rescinded all but $5 million, the $5 million being lost because that had been expended.

As a result of that change in policy, the new administration came in and suggested that an outpatient clinic facility would be a better approach—that is, a satellite outpatient facility was going to be the new approach to providing veterans with care. Veterans would be able to receive therapy, physical rehabilitation, examinations, treatment, as well as access to VA pharmaceutical facilities.

In light of the fiscal austerity we've been in since that time, the assumption is that that's the best we could do and, therefore, we have been enthusiastic about trying to get such a facility established, as the VA said it wanted to establish. That was in 1981. It is now 1987.

The VA instituted something called the Medical District Initiated Program Planning system to make the determination as to where these types of facilities would go. This is a computer-based analysis which examined all the relevant factors, the demographics, the need for such facilities. Again, to make a long story short, in December of 1984 the results of this program study came forward and made the determination that in our part of the medical district, Medical District IV, the southern New Jersey part, three counties were in the top four and, therefore, the VA concluded that the evidence was clear that that's the location where such a facility should be established. Thirty months have passed since that decision was made, growing out of the report, and we are now at the point where we still have not had a lot of action.

Members of the committee may recall that last month the Administrator of the VA presented to us the fiscal year 1988 budget, and again there is no money in that budget for this project that the administration has said is a priority project. The VA Administrator, who was here, responded that, notwithstanding the absence of authority, notwithstanding the absence of money included in the budget, they intended to go forward with a lease program that would allow the establishment of a facility in fiscal year 1988; that the clinic would be, under current projections, committed to in fiscal year 1988. Since that hearing I have received a letter from General Turnage who again reiterates the same point.

Gentlemen, myself and Congressman Smith, and the entire New Jersey delegation, have been hearing the commitments and the promises for a long enough time, and we take the Administrator at his word, that he intends to enter into this agreement in 1988. I guess what we're asking this committee to do is to include in our recommendations to the Appropriations Committee a specific, firm direction that it be done, so that we are not sitting here 1 year from now in the same situation as we were 1 year ago, and 2 years ago, when we had the same recommendations, the same promises, the same commitments made to us.

So I would just ask for this committee's support. The chairman of the full committee and this subcommittee, Mr. Montgomery, has been very generous with his time and his attention over the last number of years, going so far as to come to our area to talk to the veterans. I think he and anyone who objectively looks at the data will conclude that this is a facility that is long overdue and is absolutely needed. The VA concedes it as such. Frankly, I think the major problem is not the VA as much as it is OMB. But that's for a different forum and that's for a different time.

The point is that I—and I know I speak for my New Jersey colleagues—would ask this committee to consider directing that the VA do what it says it's going to do, and that is to, in fiscal year 1988, authorize and direct that the establishment of this facility go forward.

Thank you very much.

[The prepared statement of Congressman Florio appears at p. 70.]

Mr. PENNY. Thank you, Mr. Florio.

I think at this point we will call on Chris Smith, also a member of our committee, for his testimony on this particular project.

STATEMENT OF HON. CHRISTOPHER H. SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. SMITH OF NEW JERSEY. Thank you, Mr. Chairman.

I come before this committee joining Mr. Florio and Mr. Howard, who I think will join us shortly, on a subject that has been much discussed by members of this committee. I have raised it at least a dozen times in hearings, as well as during markups. It is an issue that is very important to New Jersey veterans—that is, the establishment of a satellite clinic in central or south Jersey.

As you know, Mr. Chairman, in the 99th Congress I introduced legislation to direct the Administrator of the VA to establish an outpatient clinic in the central or southern region of New Jersey. Last year, the full committee agreed to attach the language of the bill as an amendment to the Veterans Health Care Amendments of 1986. The full House subsequently adopted the bill. Unfortunately, in the House-Senate conference, the provision was dropped. Mr. Chairman, again, as you know, I have introduced that legislation with the full concurrence of our delegation and, of course, that of Mr. Florio and his very strong support.

For many years, Mr. Chairman, the VA has been aware of the vital need to establish a facility to serve the nearly one million veterans in the State of New Jersey. In fact, the VA, in its own MEDIPP study, indicated that the establishment of a satellite outpatient clinic in New Jersey is the highest priority within the entire Medical District IV. The VA minimum threshold to establish a satellite outpatient clinic is 15,000 service-connected visits per year. In Ocean County alone, the VA estimates that the clinic would receive 52,000 such visits per year—well over three times the minimum requirement.

Last year, Mr. Chairman, as my colleague has pointed out, we were assured by officials of the VA that the New Jersey clinic would be included in the fiscal year 1988 budget request. It was not. About a month ago, the VA provided us with a schedule of dates for the completion of the clinic. Mr. Chairman, according to this schedule, the economic cost analysis for the clinic was to be completed by the end of February. It is now approaching the middle of March and, to my knowledge, the economic cost analysis is still not completed.

I understand delays, Mr. Chairman. But given the long history of delays on this project, the time has come for additional action by the committee to ensure that this desperately needed clinic becomes a reality.

Mr. Chairman, in order to lock this clinic into the VA budget, myself, along with Mr. Florio, will be offering an amendment to the medical construction budget resolution when that comes up for consideration on March 25.

Again, just to reiterate a point that Mr. Florio made—and I think this cannot be overstated—when the Camden hospital was lost, as you know, at the initiative of the administration, Mr. Florio had led that fight for a number of years. The hospital would have provided a number of acute care beds for central and south Jersey. We then moved to another idea, an outpatient clinic. During a visit to Walson Hospital in 1983, I became aware of excess capacity and excess space at that particular facility, and initiated an idea of trying to share that facility, through a DOD-VA sharing agreement. It was contemplated, the VA agreed to it, the Department of Defense agreed to it, and then at the last minute the Commanding General at Fort Dix reneged and, unfortunately, the deal was undone. So we had an outpatient clinic in hand and it was lost. We had a hospital in hand and that was lost.

We have had a history of losing these health care initiatives, and I think if we lock it in, if this committee accedes to our request and approves such an amendment, we will go a long way to ensuring that by 1990 or sometime thereabouts we will, indeed, have a clinic in hand assisting central and south Jersey veterans.

[The prepared statement of Congressman Smith appears at p. 73.]

Mr. PENNY. Before we move on to the other members, it might be appropriate for the committee to respond, if there are members who want to respond, to the particular issue of the New Jersey medical facilities.

Mr. Montgomery.

Mr. MONTGOMERY. Thank you, Mr. Chairman.

I am thoroughly familiar, as is everyone on this committee, with the prepared outpatient clinic somewhere in Southern or Central New Jersey. All I can say, Jim, and Chris, is that we will pledge to you we'll do the best we can. We had it in the medical care bill last year, but the Senate did not accept it so it was dropped from the final version of the bill. I will do the best I can and not let it drop out this year.

If we can get the permission of the committee, we will include it in the committee construction resolution, as well as the health care bill—to put it in both measures. Then, maybe we'll have a good chance. But I give you my firm commitment that I will do everything possible as chairman of the Veterans' Affairs Committee to get it through.

Mr. FLORIO. Thank you, Mr. Chairman.

Mr. MONTGOMERY. We thought we had it last year. You have been very patient. It's time to get something done. I'm sorry about the delay. I have talked to Congressman Bill Hughes and also Jim Howard of New Jersey. They seem to be totally on board and also are very interested in this legislation.

Thank you, Mr. Chairman.

Mr. HAMMERSCHMIDT. Mr. Chairman.

Mr. PENNY. John Paul.

Mr. HAMMERSCHMIDT. I just want to associate myself with those remarks just made by the chairman. I know of the long efforts that have been made by Chris and Jim and the others. As you know, we did take the step of putting it in our budget request and, of course, it has gone over to the Budget Committee, which is a first step. But I want to join Sonny in saying we will do all we can on this committee to move that project forward.

Mr. PENNY. Mr. Staggers.

Mr. STAGGERS. I can empathize with your frustration of trying to do this year after year, and I will pledge my help, also. We see Mr. Smith on the committee every time we're here. He has almost a perfect attendance, as far as I know.

Mr. Florio, you had mentioned that year after year you come back. That doesn't mean, if we help you, you're not going to come back and see us, does it?

[Laughter.]

Mr. FLORIO. No. I would be happy to.

Mr. STAGGERS. Thank you.

Mr. **Smith of New Jersey**. I would just like to thank all of you for your demonstrations of support, not only at this hearing but throughout this process. It is unfortunate that locking it in through a legislative initiative is necessary. The administrative route is normally the preferred route but, unfortunately, in this case, it has not worked. So we welcome your support and thank you.

Mr. **Penny**. Dr. Rowland.

Dr. **Rowland of Georgia**. Thank you, Mr. Chairman.

I want to associate myself with the remarks of our chairman. I understand there is money in our report to the Budget Committee for these projects. Certainly I pledge my support, also.

Mr. **Florio**. Thank you very much.

Mr. **Penny**. I don't see any other members who are asking for recognition. But, with that, we do appreciate your testimony. I think all of us do stand ready to help in whatever way we can to include this important project in legislation during this session.

With that, we will move on to welcome two other distinguished members to the committee, Charlie Bennett of Florida and Richard Ray of Georgia. Since you're at the microphone, Charlie, we'll take you first and then move on to Richard.

STATEMENT OF HON. CHARLES E. BENNETT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. **Bennett**. Mr. Chairman, thank you for the chance to testify on the Veterans' Administration's medical construction authorization request for fiscal year 1988.

There is a serious shortage of Veterans' Administration facilities in Florida, and Jacksonville is the most populous city in Florida without a VA hospital. In all fairness to the veterans of this area, a veterans hospital should be promptly established in Jacksonville.

During the past decade, Florida has experienced a greater rate of growth in its veteran population than any other State in our Nation. With this expansion, along with a growing population base, comes the need to provide medical care and services that are mandated by law for veterans.

My bill, H.R. 68, provides for a Veterans' Administration general medical and surgical hospital in Jacksonville, FL and seeks to achieve cooperation with the University of Florida College of Medicine in its activities in Jacksonville.

Jacksonville has one of the largest concentrations of retired and active-duty personnel of any metropolitan area in the Nation. Its surrounding area has the third largest concentration of veterans in the State of Florida. This is projected to remain steady for many years to come. Yet the nearest veterans hospital for this major concentration of veterans is more than a 3-hour round trip away. Gainesville and Lake City, the two nearest cities with VA hospitals, do not even have a significant military or veterans presence, such as Jacksonville.

The increasing age and increasing numbers of Florida veterans will increase demand, very naturally. In the future, Americans are projected to live longer and demand more services, and more of them are coming to Florida. As the average age of the veteran population increases and the demands of the system grow, we must locate a veterans hospital in the Jacksonville area, one of the primary concentration of veterans. This is partly true because of the large number of active duty personnel, about 40,000 of them. This belief is echoed by the Veterans' Administration, which declares that its systematic planning efforts are designed to assure that VA facilities are located where the need is greatest. Having VA hospitals an 1½ hours away for the State's largest concentration of veterans, it seems to me, is unconscionable. Veterans health care needs in northeast Florida or Duval County now require the establishment of a veterans hospital in Jacksonville, which has the same boundaries as Duval County.

I am grateful for these hearings and I hope the committee will approve the establishment of this hospital which for many years has been needed.

Thank you.

[The prepared statement of Congressman Bennett appears at p. 74.]

Mr. Penny. Thank you, Mr. Bennett.

Are there questions or reactions by members of the committee? Mr. Montgomery.

Mr. Montgomery. I would like to thank Mr. Bennett for coming over this morning. I have the privilege of serving with Charlie Bennett, as do some other members on this committee, on the Armed Services Committee.

Charlie, we realize that so many veterans are following the sun and moving to Florida, and there are some studies underway where outpatient clinics and also some veterans hospitals should be located in Florida. I appreciate your testimony and certainly the committee will try to follow up on what you have suggested here today.

Mr. Bennett. Thank you.

Mr. Hammerschmidt. Mr. Chairman.

Mr. Penny. John Paul.

Mr. Hammerschmidt. I just want to assure our distinguished colleague, Mr. Bennett, that we are aware of the unique problem in Florida, and particularly the one that you point out to us. I want to join Sonny in saying we will do all we can to help address that problem.

Mr. Bennett. I appreciate that.

Mr. Montgomery. Would the gentleman yield?

Mr. Hammerschmidt. I would be happy to yield.

Mr. Montgomery. I would like to point out also that Charlie Bennett has one of the most outstanding combat records of any Member of Congress. We certainly appreciate your service to the country, Charlie.

Mr. Bennett. Thank you very much.

Mr. Penny. Dr. Rowland.

Dr. Rowland of Georgia. I just want to make a comment about Jacksonville and Duval County and the way that that area is growing. I have a daughter that lives there and I visit Jacksonville often. Jacksonville has been looked at in the past as a town of a paper mill and insurance companies, but that is not true any more. It is really beginning to expand and explode. I think the increasing population there deserves a look, particularly with the number of veterans coming in, insofar as the facilities to take care of those veterans.

Mr. BENNETT. Thank you very much, Dr. Rowland.

Mr. PENNY. Unless there are further comments from members of the committee, we thank you, Charlie, for your testimony this morning.

Mr. BENNETT. Thank you for your courtesy.

Mr. PENNY. Next I call on the Honorable Richard Ray of Georgia.

STATEMENT OF HON. RICHARD RAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. RAY. Thank you, Mr. Chairman.

Let me just take a minute to say that it's a pleasure to appear before you today, my first time before your committee. Your committee has a tremendous reputation for doing a good job, for its organization, and for the leadership of the committee and the membership you have gathered over a period of time. Mr. Montgomery, Mr. Penny and Mr. Hammerschmidt, I am grateful for the good job you do and for the good service you do for all the veterans of our country. You speak very well for them and represent them very well.

I appear before you today on behalf of 64,000 veterans, and that number continues to grow, who live within a 50-mile radius of Fort Benning, GA. In order to receive medical treatment at a VA facility, veterans from Columbus and the surrounding communities presently have to travel over into Tuskegee, AL, at some inconvenience, particularly to those who are disabled and have problems even making appointments to get there because of the crowded facilities, or they have to travel to the VA hospital up in Decatur, GA, which is well over a hundred miles up there.

An additional factor is that these facilities are overloaded, requiring long waits for appointments, and then additional delays once the veteran arrives.

In my office in Columbus, GA, one staff person spends practically all of their time trying to get veterans into the clinics and the hospitals and untangling the concerns and problems that they have in order to provide adequate medical treatment for them in VA facilities.

Now, Mr. Chairman, many people point to the presence of Fort Benning, GA—it's been there since 1917—in the Columbus, GA area and in the Cattahoochee Valley area, which also covers an area across the river in Alabama, and they cite the medical facilities at Fort Benning as a resource for area veterans. We are all aware that military hospitals appropriately give first priority to military personnel and their families. This means that available medical services for retirees are also limited. Providing medical service for veterans, who aren't retired, in the Columbus and Fort Benning, GA area is almost out of the question now.

The recent announcements that the Department of Defense is now in the process of selecting a contractor for a primus clinic in that area of the State, and that Georgia will be a test site for the new CHAMPUS reform initiative, compounds the problem, since veterans and others mistakenly believe that area veterans should no longer have any difficulty gettng the care that they might need.

In fact, there are two problems with this viewpoint. First, recent growth at Fort Benning, such as the addition of the 2nd Brigade of the 10th Mountain Division—a part of the light infantry division from Fort Drum, NY—the stationing of the 75th Ranger Regimental Headquarters and the 3rd Ranger Battalion, and the permanent siting of the School of the Americas, all within the last 3 years, have greatly increased the strain and the load on base medical facilities because of the active duty personnel and their dependents.

The new primus clinic and the CHAMPUS reform initiative are attempts to relieve that strain, but the first priority of base facilities will remain, as it should be, for active duty personnel and their dependents.

Secondly, as I pointed out, base medical facilities, CHAMPUS and the primus clinic are all available only to active duty, retirees, and their dependents. The vast majority of veterans are not retirees and, therefore, cannot make use of any of these facilities.

So although the Department of Defense should be commended for the various actions they are taking to relieve the problems of retirees, this does not eliminate the need for the Veterans' Administration to do something to service Fort Benning and Chattahoochee Valley area veterans.

I would like to say that Congressman Bill Nichols also joins me in expressing concern about these areas for Georgia and Alabama veterans.

Mr. Chairman, I want to present for the record a letter from the Chattahoochee Valley Veterans Council outlining the efforts of 44 veterans' organizations, auxiliaries and other associated units in the Georgia/Alabama valley area to inform the VA of the desperate need in this area for medical facilities. I ask that this letter be included as a part of the record of my testimony.

Mr. PENNY. Without objection.

Mr. RAY. Thank you.

I might add, if the committee is interested, I can supply a great number of letters from a great number of veterans now there, but I didn't see any need to bring that in to encumber your good work today.

Expectations are that the veterans population of the Chattahoochee Valley will continue to grow and, as it does, the severity of the situation for veterans will only increase without the establishment of an outpatient clinic.

The establishment of a new cemetery right across the line in Alabama—this committee had a lot to do with that—is also encouraging people to move to that area who are retirees and veterans.

Now, Mr. Chairman, the excellent work of this committee in looking after the needs of those who have served our country—and particularly your own personal exemplary efforts—are well known by all of us who represent veterans here in the Congress. I am grateful for the opportunity to make you aware of this serious problem which now faces us in this area of Georgia and Alabama, and I strongly urge your committee and the VA to take some action before the situation deteriorates further.

It is very difficult for our veterans, who were promised health care and medical treatment, to understand why they are getting what they consider to be second-class treatment. I regret that I must fully agree with them in this respect.

I want to thank you for allowing me to testify this morning and for your consideration of this request.

[The prepared statement of Congressman Ray, with attachment, appears at p. 75.]

Mr. PENNY. Thank you, Richard, for your testimony.

Are there members of the committee that want to question Mr. Ray?

Mr. MONTGOMERY. I would like to thank Richard Ray for his testimony. It's interesting, Mr. Chairman, that three out of the first five witnesses are on the Armed Services Committee. I serve with Richard, as well as others in this room.

I would just throw out an idea here. We have a sharing agreement between the military medical facilities and the VA medical facilities. It's just an idea, Mr. Chairman, and maybe our VA witnesses can address this issue. The sharing agreement is, if we have a CAT scanner in the Biloxi VA Hospital and they don't have one at Keesler Field, that they don't buy one at Keesler Field but they use the one at the VA facility. It is working and saving the taxpayers a lot of money. But it should be used more. It's just an idea, that the Fort Benning hospital could look into that situation. The VA is building a hospital in New Mexico and they will share it with the Air Force out there.

There is also another problem for our colleagues on this committee. The military hospitals, the surgeon generals, are now issuing orders turning away military retirees and their dependents. They say space is not available and, therefore, they're not able to treat them. Well, that retiree is eligible to come in to the VA medical care system. So what they don't take care of we're getting anyway, and that increases your problem of a long way to drive. It's just an idea of a sharing agreement.

Mr. RAY. I appreciate your raising that. I will tell you that at the retiree meetings that take place annually at Fort Benning, the main topic is the fact that the modern Army general hospital can't look after retirees. They feel like they were promised this service. The hospital is overloaded and it has trouble even looking after the dependents of active duty personnel. So that is raising a lot of problems.

CHAMPUS is operating very slowly. People tell me that sometimes they get a recording, and then it takes about 7 days for them to actually make the contact, and then it takes up to 15 months sometimes to get CHAMPUS to pay the bill. In addition, we're talking about veterans who aren't retired but who reside in that particular area. So we've got a real problem.

In addition to this, the private medical community is raising some very serious concerns, that if the veterans aren't going to be looked after by the VA, then perhaps the private sector should be given some sort of a contract or some sort of a privilege to be able to aid the people who are not receiving adequate service.

So your point is well made. But the problem is that attractive retirement centers are so crowded that the Army hospitals and the military hospitals can't possibly look after the military people and their dependents.

Mr. HAMMERSCHMIDT. Mr. Chairman.

Mr. PENNY. John Paul.

Mr. HAMMERSCHMIDT. Rich, we thank you for your testimony.

As I understand your problem, you've got about 60- or 70,000 veterans around there that you really can't accommodate and you need a free-standing outpatient clinic.

Mr. RAY. Yes.

Mr. HAMMERSCHMIDT. I think this is the first time that this committee has addressed itself to your problem. This is a good starting place and we appreciate your bringing the problem to us. As long as we have Roy Rowland here, he won't let us forget the needs of Georgia veterans, I assure you. We appreciate you bringing it to us and it will receive our full attention.

Mr. RAY. Thank you, Mr. Hammerschmidt. I appreciate that very much. I know this committee is responsive.

Mr. PENNY. Dr. Rowland.

Dr. ROWLAND OF GEORGIA. In that respect, to follow up on what Mr. Hammerschmidt said, it is my understanding that the Veterans' Administration has been looking at this setting in Columbus, GA for some time. Would this relieve the problem that you're discussing here?

Mr. RAY. Congressman Rowland, thank you very much for raising that question. You are correct. The VA has been investigatng the Chattahoochee Valley area as a possible site for an outpatient clinic for the last 2 years. I also understand that during this period of time they ran tests on the area to determine how badly it was needed and that they have certified that there is a need for a VA outpatient clinic there.

Dr. ROWLAND OF GEORGIA. So this is not a new issue; the VA has already been looking at the Chattahoochee Valley?

Mr. RAY. That's true. It's not new.

Dr. ROWLAND OF GEORGIA. Let me just follow up on what the chairman was addressing just a few moments ago, and that is the sharing of facilities. You mentioned DOD facilities, of course, in your statement. There are locations where veterans are allowed to use these DOD facilities.

Do you think this could possibly be a solution, by working with Fort Benning?

Mr. RAY. Well, Fort Benning is anxious to accommodate, if they can. You know, we're going to have to expand Fort Benning just to take care of the regular military people down there. So they will do what they can.

To tell you the truth, they've been a little bit incensed down there because articles have gotten in the paper that the VA has been looking around there and has not had any encouragement from Fort Benning that they will accommodate them. They want to accommodate them, and I want to assure you of that. They just don't have the room or the facilities or the personnel to do it.

Mr. MONTGOMERY. Would the gentleman yield?

Dr. ROWLAND OF GEORGIA. I will.

Mr. MONTGOMERY. As I understand it, in the Army, as well as all the other military services, there is a real problem of a shortage of medical personnel to treat the dependents, the retirees, and the regular Army. It's a possibility that we could look into sharing of VA doctors and health care professionals from the Veterans' Administration, if the space is available in that hospital—as I understand it—that there could be, under a sharing agreement, that some VA physicians and health care people who could work there.

The problem I see for this committee—and we had better start thinking about it, and the VA people that are here—we have entitlements which you don't have in health care for retired military. That is if space is available. But we have entitlements, that if a guy is service-connected and he can't get in the military hospital to get treated, then we have to find a space for him in the Veterans' Administration. So that does increase some of the problems we've got, that if the military turns them down, we have to take care of them.

Mr. RAY. Yes, sir.

Mr. MONTGOMERY. Thanks for yielding.

Mr. PENNY. Any other members?

Thank you, Mr. Ray.

Mr. RAY. Thank you for the opportunity to appear before you today. I would hope that maybe some time—I realize you have a lot of demand—but at least the subcommittee might have a hearing in Columbus on this matter.

Mr. SMITH OF NEW JERSEY. Mr. Chairman.

Mr. PENNY. Mr. Smith.

Mr. SMITH OF NEW JERSEY. I would encourage Mr. Ray to continue on in his efforts, especially with regards to the DOD/VA sharing approach or initiative.

I would just point out to him that we had a situation, again as I briefly pointed out in my testimony, at Walson hospital at Fort Dix, where the Department of Defense out of Washington and the VA had come to the conclusion that the facility had the space and that all that was necessary was to proceed. There was an agreement. And then, unfortunately, Commanding General Kelley came to the conclusion that he needed the space. Perhaps the VA witnesses could address this, but I think we are going to find there is an institutional bias, that the missions are different, and that perhaps we need to prod the Department of Defense a little more earnestly to make their space available.

You know, it is easy to say we just don't have the space, that we need that capacity for ourselves. Again, I was alerted to it myself just by taking a tour back in 1983. I saw all of this unused space and said why don't we use it for a VA outpatient facility. I think the chairman has a good idea, and it was his bill originally, as the members will recall, that established this mechanism for sharing between the two departments.

Mr. PENNY. Do any additional members want to react? If not, again, we thank you, Mr. Ray, for your testimony.

We have Representative McCurdy and Representative Rahall, who have been here for some time. I understand, though, that Chairman Howard has a time constraint. And since we have already had two witnesses on the New Jersey project, we would be happy to take your testimony as well. Then we will move on and call on Mr. McCurdy and Mr. Rahall and other members in the order that they arrived.

Mr. Howard.

STATEMENT OF HON. JAMES J. HOWARD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. **Howard**. Mr. Chairman and members of the committee, thank you very much. We have been rather busy on other legislation involving surface transportation, which we plan to have on the floor next week.

I do know that my colleagues, Mr. Florio and Mr. Smith, have been discussing this subject, which deals with my congressional district, and I want to thank them also for the work they have been doing. I wish to speak on a topic of rather great importance to a million veterans who are living in New Jersey.

In 1984, the VA conducted a study which demonstrated a need for an outpatient clinic in Ocean County, NJ. This need was evidenced by the high concentration of veterans residing in central and southern New Jersey. There is a tremendous influx from our northern city areas down to the central Jersey area. Many of these new arrivals are older people and many are veterans from World War II. Based on these findings, the VA declared that an outpatient clinic for this area was of the highest priority. However, the President did not request the funding for this clinic in his 1988 budget.

Mr. Chairman and members of the committee, I understand that the committee was led to believe funding would be included, since the clinic has been totally justified. What was proposed by the President was a significant cut in veterans' programs that would adversely affect the VA's capacity to provide health care to eligible veterans.

The White House budget allocates $27.7 billion for veterans' benefits and services, $160 million less than the amount needed to maintain the current level of veterans' services. The administration proposes to eliminate medical beneficiary travel. This, in essence, means that if a veteran cannot afford to travel to a hospital, he will be denied service. For veterans in my district, it is a long drive to the old and already crowded Philadelphia facilities and the ones up in northern New Jersey at Lyons. The establishment of a veterans' outpatient clinic in northern Ocean County thus becomes all the more necessary in light of the President's budget.

Presently, veterans in central and southern New Jersey must drive a minimum of 1½ hours to reach the nearest veterans clinic in Newark, NJ. Still others are forced to travel to either Delaware or Pennsylvania, other States, to receive care. Since 1978, when the administration first announced its intention to build a clinic, countless New Jersey veterans have waited patiently and suffered from the lack of such a facility. Given the facts, I am sure this committee understands the urgency of the need to direct the VA to establish this clinic in fiscal year 1988.

I would like to thank this committee for the personal interest it has demonstrated in the creation of an outpatient clinic in New Jersey. We have been working on this a long time. It was almost 2 years ago, Mr. Chairman of the full committee, that you joined me on our local television program and indicated your support. So we do have on record and on tape your promise, Mr. Chairman.

[Laughter.]

The veterans of New Jersey, like the veterans around the country, do deeply appreciate your commitment to their welfare. I would like to commend this committee for the steps it has already taken on this matter and urge that it continue its fine work.

I want to state that we had a meeting a week ago with the VA and with a task force of one of our larger communities in this area, a task force which has been working on this with area veterans, to study where the facility could be located and how it would work. So there has been a great deal of local effort put into this, also.

I just thank you for your attention to this matter, and I again thank my colleagues, Congressman Smith and Congressman Florio, for their work on it. Thank you, Mr. Chairman.

[The prepared statement of Congressman Howard appears at p. 80.]

Mr. **Penny**. Mr. Montgomery.

Mr. **Montgomery**. Thank you. I appreciate the chairman pointing out that I am on record. We're just going to have to get something done now. You've put me right on the spot. I work out of the same hall you do in the Rayburn Building. We said earlier we're going to do the best we can. We're going to move legislation in two separate areas and we're going right to the bottom line and try to get this thing done. Thank you.

Mr. **Howard**. I would just like to say also that the commitments from the local hospitals, which do have to cooperate in coordinate this project, have already been made so there would really be no kind of problem in that respect.

Mr. **Penny**. John Paul.

Mr. **Hammerschmidt**. Mr. Chairman, I want to thank our distinguished colleague, the chairman of the Public Works and Transportation Committee, Mr. Howard, for being here and presenting his testimony. Anybody who can put together a complex surface transportation conference bill, as he has done in the past 3 weeks, is certainly a good advocate for Chris Smith and Jim Florio and the other New Jersey people to have on their side.

I'm glad you got Sonny on the record because we have already sent this project over to the Budget Committee in the budget resolution. Thank you very much, Jim.

Mr. **Montgomery**. Would the gentleman yield?

Mr. **Hammerschmidt**. I yield to the chairman.

Mr. **Montgomery**. I want to point out, though, that we have a good replacement, but you did take away our ranking minority member on our committee, John Paul Hammerschmidt, and put him over there on your committee. We miss him, but he is still over here helping us all he can.

Mr. **Howard**. He would not be nearly as good a ranking member on our committee had he not been trained by the members here.

Mr. **Montgomery**. Some of us might need veterans care, if you have us vote on the 55–65 mile speed limit. (Laughter.)

Mr. **Howard**. I'm sure what I did yesterday made Mr. McCurdy very happy.

Mr. **Penny**. I was just going to ask Chairman Howard if he would have an objection, if we were able to exceed the speed limit in getting this project approved.

Mr. **Howard**. I think we occasionally have what we call demonstration projects, and maybe we could work that out.

Dr. **Rowland of Georgia**. Mr. Chairman.

Mr. **Penny**. Dr. Rowland.

Dr. **Rowland of Georgia**. I just wanted to assure my chairman from the Public Works Committee that you have my untiring, unrelenting, unequivocal support of this project. I just wanted you to know that, Mr. Chairman.

Mr. **Howard**. Thank you. I imagine that's about the same support that our committee has for the Talmadge Bridge down in Georgia.

(Laughter.)

Dr. **Rowland of Georgia**. Absolutely. You hit the nail on the head.

Mr. **Penny**. Mr. Smith.

Mr. **Smith of New Jersey**. Mr. Chairman, I just want to welcome the distinguished chairman of the Public Works Committee to our committee and to note that his testimony today further underscores the bipartisan nature of the support for the clinic. He has worked very hard and very long on this project. There is a very healthy competition occurring within Ocean County for the clinic, Bricktown being one of the leading areas for siting of the clinic. I just want to again thank him for his very, very strong work on this.

Mr. **Howard**. Thank you.

If I, as a Democrat, am working in Ocean County, I'm sure the gentleman knows that's de facto bipartisan.

Mr. **Penny**. Thank you very much, Mr. Howard.

Mr. **Howard**. Thank you, Mr. Chairman.

Mr. **Penny**. Our next witness is our colleague from Oklahoma, Mr. McCurdy.

STATEMENT OF HON. DAVE McCURDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Mr. **McCurdy**. Thank you, Mr. Chairman. I appreciate this opportunity to appear before the committee to discuss the urgent need for a VA medical facility in southwest Oklahoma.

It is also good to hear the chairman indicate that he has Chairman Montgomery on tape. We have him on tape, also, and that tape is getting to be more valuable every day. And, of course, it's a pleasure to see a subcommittee chairman younger than myself. I know you're doing a very good job.

Mr. **Montgomery**. I appreciate that. I'm the subcommittee chairman.

(Laughter.)

Mr. **McCurdy**. "Grandfathered" in, I'm sure, by having both the full committee and a subcommittee.

Over the past few years, several studies have been conducted by the Veterans' Administration and other Federal agencies concerning the need for the VA clinic in southwest Oklahoma. These studies confirm the great need for additional veterans medical services in this area. There are more than 70,000 veterans in southwest Oklahoma and an additional 60,000 in north Texas who would be served by this facility.

I note that two of my colleagues from Texas are members of this committee, and it is important to note that, except during football season, there is a great deal of trafficking across the Red River, which is not much of a river anyway, to Lawton and Wichita Falls. And between the Fort Sill Army installation, Altus Air Force Base, and Sheppard Air Force Base, there are in excess of 130,00 veterans in the region. There is no veterans clinic or hospital within over a hundred miles of this region.

These are men and women who have served their country honorably, and who currently have to drive several hours to be cared for at the Oklahoma City VA Hospital.

The long journey to Oklahoma City often proves too difficult for some of our veterans, especially during the winter. In many cases, the trip itself discourages them from seeking important medical services. I know of at least one constituent who died from a heart attack because his wife could not get him to Oklahoma City and the family could afford no other insurance.

Another serious disincentive for obtaining medical care is the long lead time in getting appointments at the Oklahoma City Hospital. It is usually more than 3 months before a disabled veteran can get an appointment for an evaluation—3 months. The care given at the Oklahoma City hospital is excellent, but there are too many demands on its resources. A facility in Lawton would relieve overcrowding at both Oklahoma City and Muskogee.

The Veterans' Administration identified the need for additional outpatient services in southwest Oklahoma in 1983, but for the past 4 years it has been unwilling to request the funds to make those services available. In spite of great enthusiasm from the Lawton, OK community, where the proposed services will be centered, and from the Oklahoma congressional delegation, the VA has not advanced development of the clinic except to begin a study of whether a VA-owned clinic would be more cost effective than leasing space to support a new clinic. The agency appears unwilling to request budget authority for an outpatient clinic in the area prior to the mid-1990's.

Mr. Chairman, our veterans simply cannot wait that long. We need your assistance in taking the proposed Lawton veterans outpatient clinic off the agency's backburner and placing it high on the priority list.

A recent report from the VA confirms the long-term trends pertaining to the aging of the veteran population. As you know, the proportion of veterans over age 65 has grown from 7 percent to 16 percent since 1970, and is expected to exceed 33 percent by 1995. Older people use more inpatient and outpatient medical services than younger ones. I realize that many areas of the country are clamoring for VA outpatient clinics. However, I also believe that southwest Oklahoma is unique because of the high concentration of veterans who reside in that area.

Mr. Chairman, you have taken the time to visit my district—I know Chairman Montgomery has, as I have said—and I know that you are aware of the significant veterans population. All of us in the Oklahoma congressional delegation, on a bipartisan basis, and the veterans throughout the region, are grateful for your personal interest and support.

Again, Mr. Chairman, I appreciate the opportunity to appear before this distinguished subcommittee and I will be glad to try to provide any additional informtion that you may need.

[The prepared statement of Congressman McCurdy appears at p. 82.]

Mr. PENNY. Thank you, David, for your testimony.

Chairman Montgomery.

Mr. MONTGOMERY. Since I have been recorded all over the country here, I had better show that I have tried to follow up on some of these pledges.

In the Report to the Committee on the Budget on Veterans Affairs for Fiscal Year 1988, we did include in the language that the committee recommends that outpatient clinics be established in Ocean County in southern New Jersey, in Lufkin, TX, and Lawton, OK. So we did include that.

Mr. McCURDY. I appreciate the gentleman's support, as I have said, and I think the gentleman has lived up to his word, primarily because the gentleman has seen the need in southwest Oklahoma and north Texas for a VA clinic.

Wichita Falls is less than 40 miles from Lawton, OK, and yet either area, Lawton or Wichita Falls, drives to the Fort Worth-Dallas area or to Oklahoma City, some distance away. It is a tremendous burden on those people. This is a high concentration of military installations and veterans population, and we certainly need the support.

Mr. MONTGOMERY. The staff points out to me, Mr. Chairman, that there are funds in there for the start ups of new outpatient clinics recommended by the Administration. The funds are in there, but it does not specify where these funds will go. We then made the recommendation that I just read.

Mr. PENNY. John Paul.

Mr. HAMMERSCHMIDT. Mr. Chairman, it just occurred to me, if Sonny ever gets on the Johnny Carson Show, we will establish the whole VA system for the whole country at one time just by his commitment.

(Laughter.)

Anyway, Dave, I join the chairman. As you know, we did send the project you're interested in over to the Budget Committee for their consideration, which should go a long way toward helping them decide where those funds should go which are earmarked for outpatient clinics.

Mr. McCURDY. I appreciate the gentleman. He's always been a good supporter and neighbor and we appreciate his efforts.

Mr. PENNY. The gentleman from Texas.

Mr. BRYANT. Thank you, Mr. Chairman.

I would just like to say, with respect to Mr. McCurdy's testimony, that if the people in north Texas decide to travel south down to Dallas to get treatment, they would encounter a very crowded situation there as well. I offer that in support of not only the testimony of Mr. McCurdy but also in an effort to thank the chairman, Mr. Montgomery, for forwarding to the Budget Committee the requested funds for completing the drawings necessary for the expansion of the Dallas VA Hospital. We serve about 450,000 veterans in that area there. If Mr. McCurdy's people came south, there would hardly be room for them. There's not room for the people who are there already.

So I would agree with what Dave just testified to and would take advantage of his testimony to make another pitch for our own situation in Dallas, and also to say thank you to the chairman for paying attention to it.

Mr. PENNY. Are there any additional members seeking recognition? If not, thank you, David, for your testimony.

Mr. McCURDY. Mr. Chairman, I would just like to take one moment and state, since this subcommittee does deal with VA health care issues, as you know, my wife is chief resident in psychiatry at the VA hospital here in Washington, and from her service in that institution I guess I have some vicarious knowledge of the type and quality of medical care provided. I think it is superb.

There are shortages, though, of health-care providers in the system. I think it's important that we continue to support the VA system. Certainly the efforts that the chairman and I worked on last year to direct moneys for medical research throughout the VA system, I think there's a tremendous opportunity there and a national resource that could be utilized in providing quality health care research.

I think the gentleman has provided some good direction there and it is always a pleasure to work with him on those kinds of issues.

Mr. MONTGOMERY. Mr. Chairman, may I comment. I should have said it earlier. Dave McCurdy was certainly helpful. He headed up the research subcommittee of Armed Services when it was in conference. He was the leading person in getting some armed services medical research funds transferred over to the VA, where we do a lot of the research for the military. I want to go on record with thanks for work he did. We couldn't have made it without him.

We do have a problem, Dave, just so you will be alerted, that's coming up. We are taking these AIDS patients now from the military. Somebody has got to take care of them when they're discharged. We would hope that we could some day come up through VA research with a vaccine or some type of cure for AIDS. But you have been very helpful and thank you very much for that.

Mr. McCURDY. I thank the gentleman.

Again, I thank the subcommittee for its time.

Mr. PENNY. Thank you, David.

With that, we will call on Representative Rahall of West Virginia. Welcome to the committee.

STATEMENT OF HON. NICK J. RAHALL, II, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. RAHALL. Thank you, Mr. Chairman.

Let me salute you, Mr. Chairman, and the full committee chairman, Mr. Montgomery, and each of the members of this subcommittee and the full committee for your dedication and your commitment to our Nation's veterans. I don't think it needs to be said, but I'm going to say it anyway. I believe each of the members of this committee's commitment to our veterans and your commitment to providing health care services to them in a timely and efficient manner are surpassed by none in this Congress. I salute you for that.

I do have a lengthy prepared statement, Mr. Chairman, that I am submitting for the record. I am not going to go through all of that in the interest of time of the subcommittee, but I do have an abridged version that I would like to speak from.

The President's fiscal year 1988 budget includes funding for a much needed expansion project at the Huntington, WV VA Medical Center. As the representative of this city, it is my pleasure to testify before you today on the need for this expansion project and to urge that the funds for the project be included in the fiscal year 1988 authorization legislation.

This much needed clinical improvement project has been in the planning stages for 6 years and is necessary to correct gross space deficiencies in surgery, medicine, radiology, laboratory and ambulatory care, as well as increase bed capacity to meet the projected facility needs. The plan will also allow for the replacement of major equipment items that are scheduled for replacement over the next 5 years, including radiographic equipment, laboratory analyzers, cardiopulmonary testing systems, electrocardiograph equipment, and operating room equipment.

Finally, the plan includes the construction of a 500-car parking garage, the removal of asbestos from the main hospital, the addition of sprinklers, the modernization of the old air-conditioning system, and a previously approved on-station warehouse which would equip the medical center with adequate storage space and avoid unnecessary expenditures on rented storage space.

If the proposed expansion to the Huntington facility is included in authorization and appropriation legislation for fiscal year 1988, the VA Medical Center will be able to adjust to the shifting and increasing needs of the tri-State area that it serves. If delayed beyond fiscal year 1988, however, many of the medical center's current needs will be exacerbated.

While the medical center is located on the western most boundary of West Virginia, it is of equal importance to our neighboring States of Ohio and Kentucky. It serves 144,000 veterans, Mr. Chairman, throughout nine counties in West Virginia, eight counties in Ohio, and eleven counties in Kentucky. The poulation of this area is primarily rural and is slightly older than the national average. It is also important to note that this area has the highest percentage of unemployment in the Nation and the rural areas do not enjoy adequate medical facilities.

The veterans that reside in this tri-State area depend on the availability of quality care at the Huntington VA Medical Center. As I am sure you will agree, it is not the intention of Congress for these 144,000 veterans to have to travel long distances unnecessarily to obtain their much needed and deserved medical care. There is a true and dire need for this expansion project and the services it will provide.

As members of the House Committee on Veterans' Affairs, you have great experience in understanding and addressing the health care needs of our Nation's veterans. I appreciate and applaud your endeavors in this vein. Therefore, I came to you as a fellow member of the House and on behalf of these 144,000 veterans who are served by the Huntington VA Medical Center to request that authorization of funding for the proposed clinical addition at the Huntington center be included in the fiscal year 1988 VA authorization legislation.

The President recognized the importance of this project and he did include $47.5 million in his budget for this purpose. The merits of this proposal are self-evident and I am confident and hopeful that this committee will authorize a comparable amount.

Again, I would like to thank Chairman Montgomery and each member of the Subcommittee on Hospitals and Health Care for the opportunity to testify today. While I do not have any tapes of the chairman of the full committee, I might say that I'm going to begin looking and see if we can't conjure up some, Mr. Chairman, and put them together, so we can be consistent with those who testified earlier today.

The veterans in my district and those in the tri-State area want to salute this committee and say thank you for the support and the help that you have given in the years past. They appreciate that and they will never forget it.

[The prepared statement of Congressman Rahall appears at p. 85.]

Mr. **Penny**. Thank you, Mr. Rahall, for your testimony.

Chairman Montgomery.

Mr. **Montgomery**. Thank you very much, Nick. I would like for you to know that Harley Staggers was here earlier and he wanted it to be known he is supporting the recommendations that you made here this morning.

I believe that the clinical improvement addition was recommended by the administration and by the Veterans' Administration. I am told by staff that it is included. Certainly that means there's a good chance it will be authorized by this committee. We hadn't taken it up, but certainly that helps when the administration or the VA says that we want this funding to be spent in certain places. So I think you've got a good chance and thank you for being here today.

Mr. **Rahall**. Thank you, Mr. Chairman.

Mr. **Penny**. John Paul.

Mr. **Hammerschmidt**. Nick, we thank you for your testimony. I think you're further ahead in this game than about anybody who's been here, because it's in the budget request. We're pleased for you that it is.

Mr. **Rahall**. Thank you, John Paul.

Mr. **Hammerschmidt**. Thank you for your testimony.

Mr. **Penny**. Thank you again for your testimony.

Mr. **Rahall**. Thank you.

Mr. **Penny**. With that, we will call on the Honorable Pat Swindall of Georgia. Pat, welcome to the committee.

STATEMENT OF HON. PATRICK L. SWINDALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. SWINDALL. Thank you.

Mr. Chairman and my colleagues, I, too, want to thank you for this opportunity to testify before this committee this morning about the need for a clinical addition in my district, in the Atlanta area. Like, Nick, mine, too, has been included in the President's budget, at least insofar as the fiscal year 1988 budget includes $6.8 million for engineering and planning. I think that that simply recognizes the need that most any individual who has visited this facility sees as very apparent.

As you know, the metropolitan Atlanta area has experienced significant growth over the past 10 years. It has achieved national stature as one of the fastest growing metropolitan areas in the country. The population in this area has expanded by almost 30 percent, from 1.9 million in 1975 to 2.5 million in 1985. The veterans population in this area and throughout north Georgia has increased as well during this period.

This hospital's primary service area covers 59 counties containing an estimated population of nearly four million people, with over 400,000 veterans. The Veterans' Administration estimates that by the year 2000 the veterans population will increase by 2 percent, in contrast to a decrease in the national veterans population. In addition to the steady growth of veterans in this area, the number of veterans over 65 years of age served by the medical center is expected to rise by an extraordinary 133 percent by the year 2000.

This center opened in 1966 and since then the number of patients, the range of services, and the sophistication of medical care, has increased substantially. Despite these developments, only limited improvements or expansion of facilities have taken place. Currently, the limited number of space has caused serious problems for the hospital. Inadequate departmental layouts have led to inefficient workflow, insufficient waiting space, lack of privacy, storage, and other support elements. In many instances, departments have become fragmented. Functional relationships between many critical areas, such as surgery, intensive care units, and diagnostic services are seriously inadequate, resulting in inefficient operations. Medical and surgical intensive care units are currently separated by three floors, and both intensive care units are several floors from the operating room area. Plans contained in the design of the clinical addition will alleviate these significant problems. By VA standards, this hospital is 47 percent below space requirements for the various clinical services that provide care for our veteran patients. As the hospital expands its programs in areas such as open heart surgery, chemosurgery, and long-term care for the increasing needs for the aging veterans, the need for additional space will grow dramatically.

There are presently 550 hospitasl beds, and 120 beds in the nursing home. It is estimated that by 1992, the medical center must increase the number of hospital beds to 675 in order to continue to provide sufficient health care. Currently, the Atlanta area is served by the smallest number of VA medical beds for any major metropolitan area.

Over the years, this facility has made significant contributions to the community. I cannot neglect to mention these contributions as a vital factor in the need for this project. This hospital is affiliated with the Emory University School of Medicine, which is one of the finest research medical schools in the southeast. There are over 20 various residency programs including rehabilitation, psychiatry, and radiology. The research facility is currently working on 30 VA-funded research programs and over 40 extra VA-funded medical research projects. In order to accommodate the high tech equipment and staff needed for these projects, additional space is not only necessary but it's vital.

The proposed project includes the construction of a five-story clinical addition and alteration to the main building to accommodate the new addition. Approximately 50 percent of the medical center will be upgraded and expanded to provide adequate space. The proposed addition will help the hospital achieve the basic space requirements established by the VA.

Also included in the project is the construction of 750 parking spaces in a deck formation. The 1990 parking analysis shows a need for 1,390 parking spaces. Construction of the new clinical addition will displace about 450 spaces. Consequently, a parking structure and realignment of the site circulation is essential to meet the projected requirements. As a result of these changes, we will end up with a net space of 1,495, which will more than meet the projected needs.

A significant part of this project is the removal of the remaining asbestos from over 200,000 square feet of the facility, which, of course, has already been mandated by this Congress. This work is imperative because it is holding up installation of new medical equipment, such as a microscope in the ceiling for eye surgery or x-ray equipment in the walls.

It is estimated that it would cost approximately $20 million for more than 25 different projects which would be required in the next 5 years if the clinical addition and parking deck are not built. None of these projects would have any positive impact on the space shortage and would only compound the space problems. I am sure that you would agree that it is much better to solve the problem now rather than being forced to resort to a patchwork approach to solving the problem in the future.

It is my hope that we will not have to continue to compromise medical care for these veterans. As you can tell from the figures that I have presented to you this morning, there is a desperate need that cannot be delayed any further. I strongly urge you to accept the recommendations of the national VA and approve the funding for this project.

Thank you for allowing me this time to represent the thousands of veterans in my district and throughout the State of Georgia who are served by this hospital. I want you to know that they deeply appreciate all of the help you have given them in the past and very much would appreciate your additional consideration, not only in terms of the convenience that is dictated by this project, but more importantly, the quality medical care that we owe to our veterans.

At this time I would be happy to answer any of your questions.

[The prepared statement of Congressman Swindall appears at p. 88.]

Mr. PENNY. Thank you for your testimony, Mr. Swindall.

Mr. Chairman?

Mr. MONTGOMERY. Thank you, Mr. Chairman.

Pat, thanks for coming before our subcommittee. I share your strong feeling that this design money should move forward. I think you have a very good chance. It has been recommended by the budget that was sent up here. As John Paul mentioned, Dr. Rowland is here looking after the Georgia affairs as far as veterans are concerned.

I would like also to mention for the record that Mr. Pete Wheeler, who is the State veterans officer in Georgia, has certainly done a good job, especially with the State veterans nursing homes. You have two there I believe now and maybe one under construction. But I have been to this location that you're talking about and there is room for expansion and I am sure it will be forthcoming.

Thank you for being here today.

Mr. SWINDALL. Thank you, Mr. Chairman. We appreciate your advocacy.

Mr. PENNY. John Paul.

Mr. HAMMERSCHMIDT. Thank you very much, Pat, for your testimony. As you know, the VA has requested about 10 percent of that $68 million, nearly $7 million, for fiscal year 1988, so I predict it will move forward. I am sure this committee will want to support that as well. We very much appreciate your testimony this morning.

Mr. SWINDALL. Thank you.

Mr. PENNY. Dr. Rowland.

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman.

Chairman Montgomery, thank you very much for those kind remarks. I really do appreciate the opportunity to work with this Veterans' Affairs Committee. It has been a great experience for me. I want to thank my colleague from Georgia for being here and presenting this information this morning.

Pat, I have a question or two I would like to ask you. You stated that the primary service areas was 59 counties that served about 500,000 veterans. Can you tell me how that is distributed, that service?

Mr. SWINDALL. Yes, sir, I would be happy to.

First of all, we actually serve every one of the 159 counties that comprise Georgia. But most of the concentration, the majority of the concentration, is in the northern districts. For example, between John Lewis' 5th Congressional District and my own 4th Congressional District, you have about 43 percent of the total population being served by that, inpatient as well as outpatient. But if you take in Congressman Gingrich, Congressman Darden, Congressman Barnard and yourself, you will take up about 60 percent. So most of it is concentrated in the northern district of Georgia.

But it is important to realize that this facility really services all of Georgia, primarily because of some of the support that Emory University offers. If there is a highly specialized need, then they will be transferred to the facility that is adjacent to Emory University, which this facility is.

I would also like to say, Dr. Rowland, that the veterans in my district very much appreciate the fact that you not only represent the veterans in your district but the veterans throughout the State of Georgia, including my district. Their hats are off to you.

Dr. **ROWLAND OF GEORGIA**. Thank you for those remarks.

Being a medical person, I am concerned about how the medical personnel in the hospital there in Decatur feel. What do the doctors think about the situation in the hospital there now?

Mr. **SWINDALL**. Dr. Rowland, you have probably spoken with them just as I have and have heard some of the general comments, but I would like to read to you just some excerpts from two specific doctors' letters that have been sent to me.

Dr. Delwood Collins—and I'm quoting—states: "There are no offices for physicians. The CAT scanner is in a closet. Sixty-six percent of the radiology time is lost due to obsolete equipment. And the clinic lab, surgery, research and education areas are woefully inadequate."

From Glenn Alred, the director of the hospital—and I quote again—"Elective surgeries are having to be cancelled because of the lack of operating rooms. Outpatient care is growing more and more each week. Last week we averaged 791 patients per day, compared to an average of 550 patients just last year."

I think those are fairly indicative of the type of comments you hear from the various physicians that practice there at the VA hospital in the Atlanta area.

Dr. **ROWLAND OF GEORGIA**. As a physician, I can tell you that it certainly makes it more difficult to provide quality service under those circumstances.

I thank my colleague again for being here.

Mr. **SWINDALL**. Thank you for your questions.

Mr. **PENNY**. Again, unless there are further questions from committee members, we thank you, Mr. Swindall, for your testimony.

Mr. **SWINDALL**. Mr. Chairman, thank you for allowing me this opportunity.

Mr. **PENNY**. With that, we have completed hearing from those members who are on our list today.

I would call on the gentleman from Texas, Mr. Bryant.

Mr. **BRYANT**. Thank you.

Before you go into the next segment of the hearing, I had earlier thanked the chairman of the committee for his efforts and the fact that he did include the Dallas VA project in the submission to the Budget Committee. I would like to both make the record complete in that regard and save the committee time by asking permission to insert in the record my original letter to General Turnage questioning why he did not do what the chairman of this committee did with regard to that funding.

If I might submit that letter and simply say another thank you to the chairman, that would be sufficient for my testimony, I believe.

Mr. **PENNY**. Without objection, the letter will be included in the record.

[The letter of Hon. John Bryant to General Turnage appears at p. 92.]

Mr. PENNY. I might add that if there are other members—and I know there is at least one on our list who was scheduled to testify this morning—if there are other members in addition to that member who would like to submit written testimony in support of a given project, the committee record will be kept open for that purpose.

We will now call forward Mr. Gerald Neumann, Director of the Office of Facilities for the VA. Accompanying him will be Dr. John Gronvall, Chief Medical Director, and Susan Livingstone, Associate Deputy Administrator for Logistics. We welcome you to the committee.

Dan, do you want to take a chair at the end here? And while they're getting settled, you can give a quick summary of your testimony. I already indicated that we have your written testimony included in the record.

If the panel will hold for a second, we will quickly take the testimony of Congressman Glickman, who is on our list to testify and is just now able to join us.

STATEMENT OF HON. DAN GLICKMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. GLICKMAN. I thank you, Mr. Chairman, and my friend, the chairman of the full committee, for allowing me just 1 minute. I would ask that my entire statement appear in the record.

Mr. Chairman, the administration's budget request for 1988 provides funding for colocation of the Wichita veterans hospital and the regional office. I just want to come to this committee and tell you how much I support that. I know the chairman of the full committee has indicated his support for this concept. It saves money and it provides an enormous savings in time and effort and convenience for hundreds of thousands of veterans who are served by this hospital.

This is one of the few places in the country where they are talking about colocation. Since the administration supports it, I would hope that it would go through the process formally. I just want to indicate my support for it. My statement goes into more detail.

I thank you and Mr. Montgomery for any help that you might give.

[The prepared statement of Congressman Glickman appears at p. 94.]

Mr. PENNY. Thank you for being with us this morning. We will give you the same assurance we have given others whose proposals have been accepted and endorsed by the administration. It makes it almost a certainty that they will find their way through the process and that this committee will as well lend its support to those projects.

Mr. Montgomery.

Mr. MONTGOMERY. Thank you.

Dan, I appreciate your coming before the subcommittee today. We totally support what you have testified on, the colocation of regional offices on the grounds of VA hospital centers. That is what we have tried to get pushed all over the country. We think it is really a good buy for the taxpayers. It puts the VA operations closer together and you can put the regional offices where they service the benefit accounts and also have the medical treatment. So thank you very much for taking the time to be here.

Mr. **Glickman**. Thank you. As you say, it saves a lot of money. We have an outstanding hospital in Wichita. The VA does an extraordinary job.

You know, you hear a lot about negative things in Government. Our VA, I would say to the VA folks here, does an outstanding job. The VA services its people well and putting them all in one place would help even more.

Mr. **Montgomery**. It will be located——

Mr. **Glickman** [continuing]. On the hospital ground.

Mr. **Montgomery**. How many acres are there?

Mr. **Glickman**. I don't know what the total number of acres are, but there is plenty of room, I know that.

Mr. **Montgomery**. This is one point that we've tried to make. OMB recommended that the VA sell some of these veterans hospital lands as surplus. We have been totally opposed to it because we think just what you have testified to, that you can move these regional offices on the grounds and save the taxpayers a lot of money. We want to hold on to what we've got.

Mr. **Glickman**. Thank you, Mr. Chairman.

Mr. **Penny**. Again, we thank you for being with us this morning. As a legislator who also has an interest in colocation in the Twin Cities, I am particularly interested in seeing these kinds of efforts move forward. I thank you again for being here.

Mr. **Glickman**. Thank you.

Mr. **Penny**. We will move on to the VA panel and welcome all of you who have been able to join us this morning. We will ask, Mr. Neumann, for you to take the lead in making your presentation, and then if there are others on the panel who want to make a presentation, we will accept those and then move on to questions.

STATEMENT OF GERALD E. NEUMANN, DIRECTOR, OFFICE OF FACILITIES, VETERANS' ADMINISTRATION; ACCOMPANIED BY JOHN GRONVALL, M.D., CHIEF MEDICAL DIRECTOR; SUSAN M. LIVINGSTONE, ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS; EARL BROWN, M.D., ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR FOR PROGRAMS, PLANNING AND POLICY DEVELOPMENT; AND ROBERT NEARY, DIRECTOR, OFFICE OF PLANNING AND DEVELOPMENT, OFFICE OF FACILITIES

Mr. **Neumann**. Thank you, Mr. Chairman.

Mrs. Livingstone would like to introduce the other panel members here.

Ms. **Livingstone**. Mr. Chairman, prior to Mr. Neumann's brief opening remarks, I would like to introduce the other members of our panel. To my immediate right is Dr. Gronvall, whom I believe you all know as our Chief Medical Director. On my immediate left is Jerry Neumann, who is the Director of our Office of Facilities. Again on the right is Dr. Earl Brown, our Associate Deputy Chief Medical Director for Programs, Planning and Policy Development.

And then Mr. Robert Neary, who is Director of our Office of Planning and Development with the Office of Facilities.

Mr. Neumann does have a longer statement for the record, which he will submit. But we would like to briefly summarize that and then would be pleased to answer your questions.

Mr. NEUMANN. Thank you, Ms. Livingstone.

Mr. Chairman and members of the subcommittee, we are pleased to be here before you this morning to present testimony concerning the VA's construction request contained in the President's budget for 1988.

I will summarize my remarks, as Ms. Livingstone said, and would request that my full statement be included in the record.

Mr. PENNY. Without objection.

Mr. NEUMANN. Thank you, sir.

The fiscal year 1988 budget requests a program level of $525.7 million. This amount includes an appropriation request for major projects of $400.6 million, a minor program of $121.0 million, and a parking garage revolving fund of $4.1 million. The request includes funding for construction of major replacement facilities at Dayton, OH, and North Chicago, IL.

We are also requesting funding in fiscal year 1988 for the design of a clinical addition/parking garage project at Atlanta; design and site preparation money for a new medical center in Palm Beach, FL; and funds for phase one construction of a replacement medical center at Pittsburgh, the Aspinwall division.

In addition, this budget request includes two clinical improvement projects, three fire and safety improvements projects, one domiciliary project, one outpatient improvements project, one national cemetery project, and one regional office project. The relocation of the Wichita regional office on to the medical center grounds is that project.

The fiscal year 1988 medical facility construction budget request is a product of the planning and development efforts of the Department of Medicine and Surgery and the Office of Facilities. The Medical District Initiated Program Planning Process, the so-called MEDIPP, serves as the initial programmatic basis of construction planning in the VA.

These plans, which identify medical programs and levels of service, are reviewed, modified, if necessary, and approved in the Central Office. These serve as the basis for the development by each medical center of a 5-year facility plan—a plan which identifies facility requirements and projects to correct deficiencies and to provide the necessary physical plant to meet programmatic objectives.

We have recently begun the implementation of a major initiative which we believe will significantly improve our planning process. This initiative, recommended by our consultant, Booz, Allen, and Hamilton and the RTKL report, is the establishment of a facility development plan, the so-called FDP, for each VA Medical Center. An FDP is a written, comprehensive plan for the physical development of each medical center over a specific planning horizon. The VA has begun by testing the FDP application at four medical centers. These pilot tests began in January of 1987 and will serve to guide the VA in the wider application of the FDP concept to all medical centers. We have 40 planned toward the end of this fiscal year. We would be pleased to keep the committee informed of the progress of these studies. These are going to be vital to our future.

I would also like to report on the status of the realignment of our construction activities and the formation of the new Office of Facilities. Since October 1, significant progress has been made in establishing the new Office of Facilities. Major organizational changes have been put into effect which will aid in achieving our organization's goals. These changes include streamlining the overall organization. One is the institution of a project management concept whereby one individual is responsible and accountable for each project at each facility. We also have assignment of the coordination of all construction planning activities for each medical facility to a specific facility planner. Each facility has its own identifiable planner. One last initiative is the adoption of a matrix form of operation, which provides project managers and facility planners a resource of professional, technical, and administrative expertise to draw upon, as they serve their assigned facility.

The Office of Facilities has been working closely with the departments and staff offices to ensure that full communications and support mechanisms have been and are continuing to be established.

We expect significant improvements to result from the recent realignment of our capital facilities programs. Some improvements have been effected immediately, while others will take longer. Taken together, however, we anticipate that the major changes we have made in our organization and procedures in the capital facilities program area will strengthen the program and make it more responsive to the requirements of the operating departments of the VA.

Although in existence for a very short time, the Office of Facilities and the rest of the VA have worked together to make this transition smooth and effective.

Mr. Chairman, I would like to thank you for the opportunity to appear here today, and my colleagues and I would be pleased to answer your questions that you or other members may have. Thank you very much.

[The prepared statement of Mr. Neumann appears at p. 97.]

Mr. **Penny**. Thank you, Mr. Neumann, for your testimony.

I have a few questions to start things off, and then I will call on other members. I also have several questions that I think we will submit to the VA in writing and would ask for your prompt review and response to those.

Mr. **Neumann**. You will have that, sir.

Mr. **Penny**. I am curious to know why it took 9 months after the due date for the strategic plan and the construction plan to be adopted and submitted. Who wants to answer that?

Ms. **Livingstone**. Mr. Chairman, I would like to begin by answering that the 5-year medical facilities development plan that is due to you this year will be promptly delivered by no later than June 30, 1987.

The difficulties which created the delay in the plan this year were several. Initially, we were revising the document to reflect the new requirements of Public Law 99-166, that this plan reflect more operational steps, and also reflect any mission changes that might be proposed for VA Medical Centers. As that process was going on, we had feedback from the budget process and congressional enactment of our fiscal year 1987 budget; that created some revisions in our document, since some projects were added as a result of congressional appropriations actions. So we wanted to make sure our document was accurate in that regard. Then, third, we were overtaken by the fiscal year 1988 budget cycle and the interactions with OMB and our submission of that.

We regret the delay and we recognize that it does create a hardship. I can assure you that steps have been placed in motion, including a critical path, and to ensure that the next document will be produced on time.

We do have one difficulty, and that is that much of our MEDIPP data does not come in in a way that we can use it most effectively in this document. We do have a task force that is looking at various options about the timing and the way this plan is developed and submitted. We will have those options under consideration and may be coming forward with recommendations for some changes that we might be discussing with you in the future.

Mr. PENNY. I appreciate that explanation and your assurance that steps are being taken to complete these studies in a timely manner in the future. It is not very helpful to the Congress, for this committee in particular, to get those reports a couple of days prior to a hearing like this. Again, we hope you will stay on schedule with those in the future.

Dr. Gronvall, Public Law 99-576 requires that the Administrator consider the analysis and recommendations of the Chief Medical Director before submitting construction and strategic plans. In what manner did you provide the Administrator with your analysis and recommendations?

Dr. GRONVALL. Mr. Chairman, during the entire process of the development of the plan, staff from the Department of Medicine and Surgery were involved and working collaboratively with the Office of Facilities to prepare the plan that was finally submitted to the Congress. So all throughout the process that has been done in a collaborative fashion.

Fundamentally, in the sorting of responsibility, the Department of Medicine and Surgery took the total responsibility for all program plans and program projections for each of our medical centers. The translation of that then into physical facility needs and construction projects is a responsibility of the Office of Facilities. But, in summary, we were involved in the Department throughout the entire preparation and I endorsed the final document as presented by the Administrator to the Congress.

Mr. PENNY. How many FTEE on your staff have you allotted to this function over and above your normal staffing?

Dr. GRONVALL. I have not made a specific allocation of identified FTE solely to work on this particular report. We have a number of staff in the Deputy Chief Medical Director's office, in our planning offices and our regional offices, whose principal function is collaboration with the Office of Facilities in regard to construction planning.

In addition, of course, we have a significant staff of people, both in Washington and in our regional offices, district offices, as well as the medical centers, involved in program planning, the specific part of the responsibility that is unique to the Department.

If the question is how many staff of the Department or what attributed FTE participated in preparing the specific report, I would have to do an analysis of that, which I could submit to you.

Mr. PENNY. Would you say that the staffing within your division has been supplemented in any way to make sure that you have enough people focusing on the reviews and the observations and advice that is necessary to compile these plans and reports?

Dr. GRONVALL. The staff in the Department of Medicine and Surgery at the Central Office has been significantly reduced by the fact that the Congress reduced the appropriation for our central administrative staff over the past couple of years. We have had some 20 percent reduction in the Central Office administrative staff to assist in administering the Department. So my general answer is that no function virtually within the responsibility of the Department has had supplemented staff.

We have carved out of that allocation incremental staff to assign to a very few, very high priority, new functions. The quality assurance function would be the most important one in that regard. But the general answer is no, because we have had to be reducing staff rather than expanding staff.

Mr. PENNY. I would ask counsel to follow up in this area.

Mr. MCDONELL. Dr. Gronvall, prior to the reorganization of the Office of Facilities, the staff that did that translation of the needs as reflected by the MEDIPP plan into the 5-year plan resided in DM&S. After that reorganization, they were moved over to the Office of Facilities.

Dr. GRONVALL. Correct.

Mr. MCDONELL. The law enacted last year required that you participate in that function of the translation of the needs as reflected in MEDIPP, and to what ultimately became the 5-year needs assessments.

The question that we're asking is, by the enactment of that law that still gave you a role to play in that translation, did you get any additional personnel to make that plan or participate in that plan?

Dr. GRONVALL. You're quite right, that at the time of the reorganization the principal staff group that prepared this plan was relocated to the Office of Facilities. But at that time my recollection is that nine FTE of staff who had previously been in an office called FEPAC—Facility Engineering, Planning and Construction—in the Department, nine of the staff positions remained in the Department.

When I referred to the fact that we have designated individuals in several of the offices in the Department, it is those nine FTE that I was referring to. Their function has been to concentrate on construction-related matters and the translation of our MEDIPP program plans into facility plans. That was not an increment. That was a residual then of nine staff.

Mr. MCDONELL. Could you explain to the committee how those nine function in a specific situation—I'll give you an example. In the analysis that you made for determining the state of an outpatient clinic in Duluth, MN, and defining the criteria. Did the demographics of veterans have a high priority in the consideration, or was it more the lease cost per square foot of a location, which may not be where the veterans were. How did those nine people participate in that decision making process?

Dr. **GRONVALL**. That's a good question. The work done at the Department of Medicine and Surgery is medical program planning to meet and identify medical needs in the Duluth-Superior area. That really falls within the jurisdiction of our MEDIPP planning system. So the primary involvement of the Department in that specific regard was through our MEDIPP or program planning, to define a population of veterans, the medical need, ensure that the projection for a clinic would respond to that need. So that was done by the Department.

I can't tell you, with any degree of specificity, about the specific function of any of the individual nine members that I referred to. Dr. Brown may be able to amplify that.

Dr. **BROWN**. There are some of those nine who have been assigned to the planning office—three FTEs, as a matter of fact, are entirely related to what you mentioned.

Mr. **McDONELL**. Let me ask a specific. In the determination of the Duluth-Superior area—which I understand at first was called Duluth, and then it became Duluth-Superior—where did the large population of veterans be determined to be in your demographic studies?

Dr. **GRONVALL**. I can't——

Mr. **McDONELL**. Were they in Minnesota or Wisconsin, I guess is what I'm saying?

Dr. **GRONVALL**. The projection for that clinic takes into account a population of veterans residing in both Minnesota and Wisconsin. That population of veterans to be served was defined through a program planning effort of the Department of Medicine and Surgery.

Mr. **McDONELL**. So they did determine where the highest concentration was, did they not?

Dr. **GRONVALL**. Yes. I don't have that information at my fingertips, but we would be pleased to submit a description of the population to be served that would identify how many are in Minnesota and how many are in Wisconsin.

[The material referred to appears on p. 105.]

Mr. **PENNY**. As I indicated before, we have some other questions as well that get at some specific items within the construction budget, and we will be submitting those to you and would expect a prompt response from the VA on those matters.

With that, I will move to other members of the committee. John Paul Hammerschmidt.

Mr. **HAMMERSCHMIDT**. Thank you, Mr. Chairman.

Mr. Neumann, let me ask you to explain how your new facilities development plan, the FDP, fits into the MEDIPP process. Does it replace it or expand on it, modify it, or is it a separate endeavor? Or would you prefer that someone else respond?

Mr. **NEUMANN**. No. If I could start it, and then ask for assistance from Mr. Neary to my left here, who is in direct charge of the facility development planning process.

Basically, the facility development plan for each facility begins where MEDIPP ends. The MEDIPP outputs such as the staffing and the other demographic information that Dr. Gronvall was referring to in his previous response, as well as the programs planned for that particular facility, are inputs to the facility development planning process. It begins there. These then are translated to the need in terms of a facility, starting with a definition of need in functional terms—do we need more space in surgery, for exmaple.

We then proceed from this definition of need stage to identify strategic solutions to meet this need, given the deficiencies of the space and other features that we find.

Mr. HAMMERSCHMIDT. So MEDIPP just determines your needs, and then you didn't really implement anything; that's what you have FDP for?

Mr. NEUMANN. That's right.

Mr. HAMMERSCHMIDT. You took this information and used it to promulgate plans?

Mr. NEUMANN. That is right.

Would you like to elaborate on that response, Mr. Neary?

Mr. NEARY. Mr. Hammerschmidt, as Mr. Neumann indicated, MEDIPP provides the programmatic basis for facility planning. The facility development plan then takes the MEDIPP information and, working with all the various individuals involved, forms a translation of that into a long-range facility plan for each VA Medical Center. That plan then, the FDP, forms the basis from which specific project plans would be developed in the future.

I might also say that I think MEDIPP is more than simply the data involved. MEDIPP's process involves people at district and regional offices. In the FDP, those various individuals participate with the VA Central Office people and our contracted support to make that translation and develop that plan.

Mr. HAMMERSCHMIDT. So in developing through the FDP process, you bring in a director from a regional office, or hospital director, either one?

Mr. NEARY. Yes.

Mr. HAMMERSCHMIDT. They're all involved in that planning, along with the central office?

Mr. NEARY. Yes. The bulk of the activity takes place at the medical center level, with the medical center personnel, under the leadership of the director, and with representation from the regional director and the district staff involved.

Mr. HAMMERSCHMIDT. Mr. Neumann, how reliable have been your recent construction estimates as contained in the budget documents?

Mr. NEUMANN. I don't have any specific statistics. I'm not aware that we're having a great deal of difficulty. We have had two or three surprises in this past year. We are suffering some problems from overruns on projects under construction that have depleted our reserve to an extent that concerns us. I think our basic estimates, however, have been holding up fairly well, Mr. Hammerschmidt.

Mr. **Hammerschmidt**. I wonder if you would supply for our record, let's say for the last 3 or 4 years, your experience on that subject.

Mr. **Neumann**. The final cost of the project as compared to its budgeted cost?

Mr. **Hammerschmidt**. Yes, the budgeted dollars.

Mr. **Neumann**. Yes, sir, we certainly will.

Ms. **Livingstone**. Mr. Hammerschmidt, if I might add to that, we performed that same analysis—and we would be pleased to quickly furnish that for the record—on bid deviations. In the last 5 or 6 years, there has been a very strong percentage of bid deviations because the market conditions have been very volatile, and many projects with budget estimates made at earlier time came in for award when construction prices being received were very good. Our bid deviation for 1986, however, is very, very narrow. We're either very close to the mark or we're over—I mean, the bids coming in are over. So it's a very interesting sequence of events that I think demonstrates very much the current market conditions.

Mr. **Hammerschmidt**. If you've already done that analysis inhouse, then you might as well supply it for the record. There's no need to make work.

Ms. **Livingstone**. We would be pleased to provide that.

Mr. **Hammerschmidt**. Thank you.

[The information appears at p. 105.]

Mr. **Hammerschmidt**. I see my time is up, Mr. Chairman. Thank you very much.

Mr. **Penny**. We'll get back to you if you have additional questions.

Mr. **Hammerschmidt**. No, I'll submit them for the record.

Mr. **Penny**. Mr. Rowland.

Dr. **Rowland of Georgia**. Thank you, Mr. Chairman, and I thank all of you for being here this morning.

I have a question for Mr. Neumann, I suppose. I want to talk about the unobligated construction balance. How much money, Mr. Neumann, is in that unobligated account for construction at this time?

Mr. **Neumann**. At this exact moment, I'm not entirely sure. I do know what we project for the ending of the coming year. We project that we'll have about $800 million in unobligated funds at the end of this fiscal year. In the budget year, we are projecting we'll have a further reduction to get it to a level of around $600 million.

I might point out that in the last 5 budget years, including our estimate for 1988, that our unobligated balance in the major program has been reduced by nearly $500 million. In the minor program, it dramatically turned around in the last 2 years. The unobligated balance is now going down to the point where we probably will be below $100 million by the end of 1988.

I'm not sure I'm being responsive to your question. I could ask staff with me if we have an estimate of what it might be exactly today. It's probably quite a bit higher than the $800 million figure because we have several very large awards to make yet this fiscal year, which will lower the balance to the predicted level.

Dr. **Rowland of Georgia**. Last year, then, it was even higher than this year, and you expect even less next year; is that what you're saying?

Mr. **Neumann**. Yes, sir. I think we're on a downtrend. This is partly the result of reduced appropriations. You know, we were being funded at the billion dollar level and we're now at about the $600 million level. So I think that's part of it. But also I think we found ways to turn the work around quicker. The new device called the design fund has helped us, which allows us to design a project a year prior to getting the construction funds, and then we can obligate the construction funds in the same year that the Congress provides them. So that has helped us a lot in reducing the unobligated balances.

Dr. **Rowland of Georgia**. What do you do with that money while it's in that fund? Is it invested to draw interest or what?

Mr. **Neumann**. No, sir.

Dr. **Rowland of Georgia**. Is there any reason why it shouldn't be invested and draw interest? Would that help, if you could do that?

Mr. **Neumann**. I don't know if that's appropriate, sir. I would have to call the General Counsel staff. I don't know if we have the authority.

Dr. **Rowland of Georgia**. I was just asking.

Dr. **Gronvall**. Dr. Rowland, someone else could maybe speak to this, but my understanding is that the actual dollars, in fact, are not sitting in an account idle somewhere. The Veterans' Administration receives through the appropriation and budgetary authority the obligated funds. The appearance of the actual dollars and the expenditure of them does not occur until an actual payment is requested within that active project that's been obligated. So, in short, the money is not sitting, lying fallow in an account.

Dr. **Rowland of Georgia**. So you don't draw the money down when it's appropriated. You don't draw it down——

Dr. **Gronvall**. We have obligational authority to obligate funds, but the money is not drawn down until the project is actually under construction.

Dr. **Rowland of Georgia**. Let me move to something else.

As I understand it, when a veteran is in a State veterans home and has to leave that home—for whatever reason, to go to the hospital—if for more than 96 hours, then after that we terminate the payments by the Federal Government. Is that correct?

Dr. **Gronvall**. I'm not aware of the problem you're speaking to.

Dr. **Rowland of Georgia**. That is a problem that has been called to my attention. For example, if a veteran in a State veterans home has to leave and goes to the hospital, the Government will pay for 96 hours of—what is it, 17-something dollars? But after 96 hours, that payment is stopped. Of course, if this is true, then this causes a real problem. The veteran who has to stay in the hospital for 2 or 3 weeks loses that bed, or the State is not collecting.

I would like for you to find out about that.

Dr. **Gronvall**. I'm unfamiliar with the problem, but I certainly will be pleased to look into it. We may need to talk to you further to get more specific details. We will surely follow up on it and reply to you on it.

(Subsequently, the Veterans' Administration furnished the following information:)

VA policy as regards payments to State homes is consistent with the intent of the law as contained in Section 641 of Title 38, U.S.C. Specifically, the law authorizes the Administrator to pay each State, at the prescribed per diem rate, for each veteran who is receiving care in a State home, provided the veteran is eligible for such care in a Veterans' Administration facility.

The payment of per diem rates to State homes is for the direct care of patients who are occupying operating beds. VA per diem is not paid for any portion of a continuance period of absence of more than 96 hours, nor for any day when a patient is hospitalized in a VA hospital or a non-VA hospital at VA expense.

The payment of per diem to a State home for a patient who is, at the same time, occupying a bed in a VA facility, or a facility under VA auspices, is tantamount to a double benefit which is inconsistent with accepted accounting practice.

Because the demand for State home beds far exceed the supply, it is considered unfair to other qualified patients seeking admission to the State home to "hold" a bed for a period in excess of 96 hours. This allows the State home to occupy the bed without a loss of revenue which would automatically occur under the greater than 96-hour period of absence termination of aid policy.

Dr. **ROWLAND OF GEORGIA**. One other thing that I want to ask you about.

I see that the VA has requested $4.1 million in new budget authority for the parking garage revolving fund. How long will it be before those fees are going to be collected? It is my understanding that one parking garage is being built in California at this time, is that right?

Ms. **LIVINGSTONE**. Dr. Rowland, if I might respond to that, the first parking fee that will be triggered under the parking revolving fund will be with a lease, which is in excess of $100,000, in accordance with the law. We are currently looking at that lease at the Chicago (Lakeside) Medical Center and that would be the first initiation or trigger for fees.

Then the second trigger for fees will be any other leases that exceed $100,000, or the activation of a parking structure in excess of $500,000. The first four parking structures which will be funded under the parking revolving fund are San Francisco, CA, Baltimore, MD, Durham, NC, and Syracuse, NY. In the order of completion, the first one to be completed should be the San Francisco parking structure, so that will be the first garage which would trigger the parking fees under the provisions of the law.

Dr. **ROWLAND OF GEORGIA**. I see my time is up, so when you get back to me, I will pursue that.

Thank you, Mr. Chairman.

Mr. **PENNY**. Mr. Bilirakis.

Mr. **BILIRAKIS**. First of all, Mr. Chairman, I have an opening statement I would like to have entered in the record.

Mr. **PENNY**. Without objection.

[The prepared statement of Congressman Bilirakis appears at p. 106.]

Mr. **BILIRAKIS**. Dr. Gronvall, as you probably expect me to do, I would like to go into the expansion of the nursing home care unit in Tampa. I recall that last year the need for the addition of 120 beds was basically at the top of the priority list as far as the Veterans' Administration was concerned; isn't that true?

Dr. **GRONVALL**. Yes, sir.

Mr. Bilirakis. Now, I know it was a part of our budget when it left here. Was it a part of your proposed budget? Do you remember that, sir? It was at the top of the priority list, but I mean in terms of actual dollars allocated to it.

Dr. Gronvall. In the 1988 budget request?

Mr. Bilirakis. In the 1987 budget request.

Dr. Gronvall. Can someone help me? On specific funding for the TAmpa project.

Mr. Bilirakis. I tried to get the same help up here and we're not certain whether it was or not.

Dr. Gronvall. Mrs. Livingstone recollects that it was specifically requested from OMB in the 1987 budget.

Mr. Bilirakis. Of course, it left here with those dollars in there, and then somewhere in the Appropriations Committee, I understand—I was told how it happened—it was waylaid and we lost it. I hope the same thing doesn't happen this year.

My question is, considering the increase in population of aging veterans and their needs—and I think we all would acknowledge their needs, certainly in Florida, if I may be provincial—why is it not at the top of your priority list this year, or why is it not included in the budget for this year?

Dr. Gronvall. The budget, as submitted this year, Mr. Bilirakis, is based on a reconsideration of a number of factors. You will recall that last year's budget projected a strategy for changing the mix of nursing homes in such a way that we would rely more heavily on both State homes and community nursing homes. That is a reason why, as we presented our budget request for 1988 and went through executive branch review, there are no specific separate nursing home projects included. There are nursing home beds included in our 1988 budget by conversion of existing hospital beds to nursing homes, and there is a nursing home bed component in the North Chicago major clinical addition project. But there are no separate or free-standing nursing homes in this budget this year.

Mr. Bilirakis. Has it been dropped in priority, then? Is that basically what you're saying? Does that translate into a reduction or a drop in priority?

Dr. Gronvall. I would not identify a change in priority of that individual nursing home project. All of the nursing home projects that have been in the planning pipeline were judged in the executive branch review of our budget and did not meet a high enough priority to be included in the President's budget.

Mr. Bilirakis. Well, you certainly wouldn't fight the need for the additional 120 beds at Mountain Home, TN, and at Tampa, would you?

Dr. Gronvall. We have had planning underway for some time projecting a need for nursing home beds, and those projects have been identified in our planning, yes, sir.

Mr. Bilirakis. Will the Appropriations Committee counsel with you in terms of determining the final appropriations for the VA budget?

Dr. Gronvall. Well, we have had formal hearings with both the House and Senate Appropriations Committees. During those hearings, a number of questions were asked about nursing home projects.

Mr. BILIRAKIS. I guess I would hate to see an input from the Veterans' Administration that would shoot down the additional 120 beds again. That's the bottom line, I suppose, of what I'm getting at.

That isn't likely to happen?

Dr. GRONVALL. We plan no further action on that. I think as the Appropriations Committees get into the process of actually developing bills, quite typically they will ask us for additional information, request details, you know, get information from us about the background of the projects that have been in planning, so I would anticipate that that likely will happen.

Mr. BILIRAKIS. Mr. Neumann, you talked about the facility development plans, the FDPs.

I see my 5 minutes is up already. May I have just one quick moment, sir?

Mr. PENNY. Proceed.

Mr. BILIRAKIS. You refer to the FDP and it sounds like a good concept. But then you're talking about testing the FDP application in four medical centers—Marion, IL, Marion, IN, Long Beach, CA, and Northport, NY—and certainly I'm not going to quarrel with those particular locations.

But I am wondering, when we consider the uniqueness of a State like Florida, for instance, Atlanta and whatnot—the South, basically—we have the "snowbirds" down there. We fondly call them "snowbirds". They're taxing the facilities, a fantastic taxing of facilities during certain months of the year. When it's cold up here, they go down there. Those people that go are a part of the veterans population in the States they come from, but they go down there for as much as half of the year and tax the facilities in Florida, if you will.

I am just wondering, wouldn't it have made sense if also the FDP would take into consideration what the facilities are down in Florida or some of these areas that maybe have these "snowbirds", so that you could really get a better picture?

Ms. LIVINGSTONE. Mr. Bilirakis, in terms of the FDPs that are planned for contracting in fiscal year 1987, indeed, there are several medical centers in Florida that are included. A Florida facility was not included as one of the test sites—for several reasons. I would ask Mr. Neumann or Mr. Neary to explain more about the criteria for selecting the four specific test sites.

Mr. NEUMANN. Quite frankly, we were on an accelerated course to get these underway. What we did, Mr. Bilirakis, was attempt to identify something that was already in the pipeline, that had available resources in terms of a designer and a consultant who could take our new proposed statement of tasks and move very rapidly for purposes of the pilot tests. It was strictly an expedient.

These four locations you mentioned were already in our pipeline with appropriate available outside consulting assistance that could take our statement developed in-house and test it for us while we selected the forty to which we would address FDP efforts in fiscal year 1987. It was an expedient, on how we could move as fast as possible.

Mr. BILIRAKIS. As I said before, I have no quarrel with your selecting those particular four. But I don't think the VA really gets a true picture of taxing of facilities, if you will, if they don't take into consideration the "snowbirds" again that I referred to earlier.

Mr. NEUMANN. Again, as Ms. Livingstone said, Florida is heavily involved in the very first group of 40 for which we will do formal FDPs.

Mr. BILIRAKIS. Thank you.

Thank you, Mr. Chairman. I appreciate your giving me the extra time.

Dr. GRONVALL. Mr. Chairman, perhaps I could add a comment to Mr. Bilirakis' question because I think there is some important information.

In regard to the operation of our hospital system, the budget allocation process that we use takes into account the actual medical care delivered by each of our medical centers in a way that is totally independent of where the veteran happens to live. In other words, a veteran whose legal residence is in another State, but who utilizes the services of one of our medical centers, that medical center gets credit for that medical care and that is reflected in the subsequent budget allocations to that medical center.

Mr. BILIRAKIS. That's the DRG concept?

Dr. GRONVALL. Yes, sir.

Mr. BILIRAKIS. Does that come out in the wash at this point, Doctor? In other words, has it basically caught up with the need for the dollars? I know that was intended to——

Dr. GRONVALL. No, not fully, but we're moving in that direction. So I think the system that rewards workload is a principal factor for ensuring that as we allocate the funds, as the veteran population moves or the workload moves, our allocations or reallocations of funds will stay based on that fact.

Mr. BILIRAKIS. Thank you, sir.

Thanks again, Mr. Chairman.

Mr. PENNY. Do you have questions of this panel, Mr. Smith?

Mr. SMITH OF NEW JERSEY. Thank you, Mr. Chairman.

First of all, I want to observe to the panel that I'm sure you saw the very visible and strong support expressed this morning for the Ocean County facility. I know the VA is committed to this and it's just a matter of when. We will be doing what we can, as I said before, to lock this facility in so we don't lose it.

Perhaps you could tell the committee if any decision been made relative to leasing or buying or purchasing a facility?

Ms. LIVINGSTONE. Mr. Smith, as you indicated this morning, the economic cost analysis has not yet been completed. We did have a team up there that was gathering the market data for us to run that on February 18.

As you know, Ocean County is a very large county, a very complex county. I think there are 32 or 33 municipalities with different tax assessment offices in each, so the data-gathering process has been a little more difficult than we anticipated. In addition, we did have some difficulties in getting rental values and some insurance information, but I understand now we're working with brokers and appraisers in the area and that information is now available. We hope to be able to now complete the economic cost analysis some time during the week of March 16.

At that time, based on the results, it would be forwarded to the Department of Medicine and Surgery and Dr. Gronvall for analysis, to make a determination based on the economic cost analysis. If he determines leasing as the most appropriate option, then a recommendation will be forwarded to the Administrator for approval.

Mr. SMITH OF NEW JERSEY. Is the Jackson Township site under consideration? As I think you know, the township itself is willing to donate 10 acres of land to such a project.

Ms. LIVINGSTONE. Yes, sir, I heard that. There have been no townships in Ocean County specifically excluded. I understand that at this time there are two basic criteria which we will hope the site will be able to fulfill; that is, that it will be within approximately 10 minutes of a Level 2 or tertiary care hospital, in order to provide care for veterans in the outpatient environment that's required at a higer level, and that, in addition, it have convenient access to one or both of the major arteries in the State, which as I understand are Route 70 and the Garden State Parkway.

Mr. SMITH OF NEW JERSEY. Thank you.

Mr. PENNY. Dr. Rowland, did you want a few more minutes with this panel?

Dr. ROWLAND OF GEORGIA. Yes, I do.

Mr. PENNY. I think we can arrange for that, and then we're going to have to move on to the service organizations.

Dr. ROWLAND OF GEORGIA. All right.

Mr. PENNY. They've been waiting patiently.

Dr. ROWLAND OF GEORGIA. I just want to talk about the nursing home plans. As I understand it, in the 5-year plan there is just one nursing home that has been put in there. Our committee has authorized nursing homes in Tampa, Mountain Home, Palm Beach County, and Wilkes-Barre.

My question to you is, if we are able to get this authorized and get the money appropriated for it, will you be ready to go with these?

Dr. GRONVALL. Yes, sir. We have reviewed each of the projects to be sure that we're prepared to proceed if the projects are authorized and funded.

Dr. ROWLAND OF GEORGIA. That's real good, because I have some concern that maybe sometimes OMB is sort of telling us what we need to be doing about expansion of facilities, particularly with nursing homes. Do you have that kind of feeling at all?

Dr. ROWLAND OF GEORGIA. I don't know of any other way to put the question.

Dr. GRONVALL. The budget of the Veterans' Administration is part of the President's budget. The final approval of what is included in that budget is made by the Office of Management and Budget.

Dr. ROWLAND OF GEORGIA. I see. But, then, if we move ahead, of course, you would go along with what we say; is that correct?

Dr. GRONVALL. Well, when an appropriation is made, the President signs the appropriation before it goes into effect. At that point in time I have no problem whatsoever, in that the legislative branch and the executive branch have both endorsed the program and, as far as I'm concerned, there is no more discussion. We do it.

Dr. ROWLAND OF GEORGIA. Absolutely.

Thank you.

Mr. PENNY. I thank this panel for their participation in this morning's hearing. We do again have some written questions that we will want you to respond to, and we would hope you do that in a timely manner.

With that, I will call forward the next panel, which includes Paul Egan and John Sommer of the American Legion, as well as Dennis Cullinan from the VFW. Any written testimony, as always, will be included in its entirety in the committee record. You are free then to summarize your testimony as you wish.

We will call on Mr. Egan first. Welcome to the committee, and thank you for your patience. It is unusual, but under-standable, that we would have as many legislators testify this morning, but in an area of legislation such as construction projects, you can understand how many Members of Congress have particular concerns that they want this committee to address. For that reason, we had quite a few members who we had to give some time this morning. We appreciate your waiting in order to get your shot at the committee.

STATEMENTS OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AND JOHN F. SOMMER, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; AND DENNIS M. CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. EGAN. Thank you very much, Mr. Chairman. As always, we appreciate the opportunity to be here.

John Sommer, our Deputy Director of the National Veterans Affairs and Rehabilitation Commission, will summarize for us.

STATEMENT OF JOHN F. SOMMER

Mr. SOMMER. Thank you, Mr. Chairman.

The American Legion would like to take this opportunity to commend the committee for its recommendations to the Budget Committee relating to the VA construction program. We were pleased to see the recommended addition of $15 million to the budget for the clinical addition, renovation to Building 2, and the spinal cord injury center at the Dallas VA Medical Center.

The extreme need for these projects was expressed in the site visit report following a survey by an American Legion field representative in March of 1984. In addition, a routine survey of the Dallas Medical Center was conducted only last week and the urgency of the need for these projects was reinforced. Our current updated concern will be documented in the site visit report that is being prepared as we speak here.

The American Legion was also grateful to the committee for expressing its concerns on the issue of VA nursing care through the recommendations of two positive plans of action to the Budget Committee. These, of course, relate to the VA policy on nursing home beds owned by the agency; and the restoration and addition of several projects in the fiscal year 1988 budget.

Although not directly related to construction, we were again pleased to see a recommendation for an increase in the per diem rates payable to State veterans homes. The American Legion is mandated to support an annual review and revision of these rates.

We would like to express the concerns of the American Legion on two specific problems which were spelled out in detail in our statement. Those are the proposed closure of the satellite outpatient clinic at New Bedford, MA and the mission change at the VA Medical Center in Walla Walla, WA.

With respect to New Bedford, the principal VA arguments for closing derive from the low patient load and the proposition that better care can be provided at the VA Medical Center in Providence, RI. The veteran constituency in the New Bedford area has vehemently counterargued that travel to Providence and other VA Medical Centers would be a burden to the veteran population in that area and that, with improved equipment and staffing, the caseload would increase to a cost-effective level at New Bedford.

In the case of Walla Walla, the VA has announced its intention to discontinue inpatient capability at the end of fiscal year 1987, maintaining only outpatient services at that facility after that time. Veterans requiring hospitalization would be referred to Spokane, Seattle, and Portland, OR. Here again, we confront the matter of cost effectiveness as opposed to the burden of travel and other problems that would be placed upon the veterans and their families in that area.

We would ask that the subcommittee take a close look at both of these situations. The American Legion stands ready to cooperate with and assist you in any way that we can with these matters.

Mr. Chairman, that completes our summary.

[The prepared statement of the American Legion appears at p. 107.]

Mr. PENNY. Thank you for your presentation. We look forward to your assistance in pursuing those two recommendations in particular. In fact, earlier I indicated to the VA that we would be submitting particular questions and those are among the items that we will be pursuing.

Mr. SOMMER. We certainly appreciate your efforts on these issues.

Mr. PENNY. Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you, Mr. Chairman. I will summarize.

On behalf of the membership of the Veterans of Foreign Wars, I wish to thank you for this opportunity to present our views on the VA construction authorization for fiscal year 1988.

In order to provide veterans with the very top level of care they have earned, the Department of Medicine and Surgery must have a modern physical plant capable of fully accommodating modern innovations and technology. It is with this fact in mind that we now offer our comments on the VA construction authorization.

Considering the health care needs of the aging veteran population will continue to increase and place a steadily greater demand on the VA's delivery system, the administration's proposed medical care construction authorization, although not completely deficient, is still highly inadequate to properly answer surging demand.

For example, the administration is requesting $190 million in budget authority for the replacement and modernization activity. This is over $102 million less than the authority provided in 1987, and a precipitous $211 million less than was authorized in 1986. This proposed reduction completely flies in the face of the fact the demand on the VA's Department of Medicine and Surgery's physical plant is now on the rise and that this activity has suffered from underfunding through the years. If implemented, this reduced funding level for the replacement and modernization activity would only aggravate an already very bad situation.

The new budget authority would provide for the modernization of four VA facilities. When one considers that there are 172 medical centers, many independent free-standing outpatient clinics and nursing home care units, the administration's funding request may only be viewed as being extremely modest. It is our assessment that in order to keep abreast of modern construction needs as they relate to new equipment and the efficient treatment of patients, this replacement and modernization activity authority must be greatly increased.

It has been argued in certain circles that higher discharge rates and different bed models will decrease the need for some major construction. This is, in our view, extremely precarious logic, because, as stated in the operating budget, the VA is experiencing an increased workload.

It should also be pointed out that these workloads are integrally tied to changes in the private sector, and the VA may well be overwhelmed in the next 5 years if adequate preparation is not implemented immediately.

The proposed fiscal year 1988 authorization would provide $4.5 million for VA nursing home care. This is only $700,000 more than was provided in the last fiscal year's abhorrently low funding level for nursing home care which was, in fact, practically $15 million less than what was provided in fiscal year 1986. This absurdly low funding level will completely preclude much needed construction.

The strained argument has been put forth that no new funds for new nursing homes need to be provided because the VA can secure nursing home care through community and State programs. This, in our view, is preposterous. The VA may very well soon have to go begging for private nursing home care space when certain medical centers and their attached nursing home care units are full.

The VFW applauds the provision of over $11 million for the VA domiciliaries activity. This is certainly a step in the right direction.

The VFW supports the increase of almost $27 million over fiscal year 1987 in the VA outpatient improvement activity, which would bring the budget authority for this essential activity to $28.1 million. With increasing emphasis being placed on treating veterans in the community rather than through institutionalization, this increased budget authority is certainly well advised.

The VFW is concerned that a sufficient authorization be provided for grants for the construction of State extended care facilities. It is our contention that this would assist the VA in reducing the number of backlogged applications on hand from the States and should result in more extended care beds being available sooner. The request for $42 million is certainly not amiss.

We would also comment on the fact that the VA is reviewing the colocation of various regional offices on to the site of medical centers nearest the facility. In this regard, we would only be in favor of colocation where it could be clearly shown that it would benefit veterans. Regional offices should be only colocated with medical centers where there is ample space for modernization, parking, and adequate access to public and private transportation for VA beneficiaries.

Mr. Chairman, thank you. That concludes my statement.

[The prepared statement of Mr. Cullinan appears at p. 113.]

Mr. PENNY. Thank you, Mr. Cullinan.

I am not sure that any of you have had a chance to look over the 5-year facility development plan because the committee itself only received that in the last day or two. I know you talk on the horn with the committee to get every bit of information that we have as soon as we have it, but I don't think you have seen this plan. But in looking over the plan, it does provide a recommendation for only one VA nursing home care unit in the next 4 years. That would be at New Orleans.

Mr. Cullinan, you have already spoken to the need in this area in your testimony. If you want to elaborate any further in response to this 5-year plan, I would welcome that testimony. But, for sure, we would like to hear what the American Legion has to say about the 5-year plan for nursing home care.

Mr. CULLINAN. I would only say we're concerned about what this facility development plan would show to begin with and that our concerns are well founded. Just providing one nursing home is ridiculous.

Mr. PENNY. Mr. Sommer.

Mr. SOMMER. Mr. Chairman, the American Legion expressed its concern last year, during the fiscal year 1987 budget testimony and hearings, on the administration's "plan for the future" as far as VA nursing home care is concerned, in that no new independent nursing homes would be constructed under that plan. We are very much concerned about that and we reaffirm that concern this year in our statement to the full committee on the fiscal year 1988 VA budget. It is a great concern to us. We don't think that OMB is headed in the right direction in this case.

We certainly have no quarrel with the use of community nursing home beds, and we certainly understand the great work that the State veterans homes do, but we don't think that that alleviates the need for the administration to build additional VA nursing home facilities.

Mr. PENNY. Thank you.

I call on Mr. Smith for any questions he might have of this panel.

Mr. SMITH OF NEW JERSEY. Thank you, Mr. Chairman. I don't have any questions, but I would share the concern of our witnesses regarding the administration's recommendation, or their "plan for the future" as they put it, that no nursing home construction occur. I think that is, as you put it, absurd. I would suspect there are many people within the VA itself who feel the same way and perhaps feel that OMB or other bureaucrats are putting the pressure on to come up with that kind of recommendation.

I know in our own State we have a great need, an increasing need, for nursing home care utilization. With the prospects of an aging veteran population, it will only put further pressure on that need. So I think, rather than opting out, we should be getting more fully involved.

I would suggest, too, Mr. Chairman, since the veterans organizations always are last, that perhaps there could be a change in protocol in some subsequent hearings, at a time when more members would be available, and have the veterans organizations make their presentations first. I think that would be very suitable and would recommend that.

Mr. **Penny**. I appreciate that recommendation. If I ever get to be chairman of the committee, I'll keep that in mind. (Laughter.) But I think in fairness to Chairman Montgomery, we give pretty good attention to the veterans organizations around here. I know that, even though some members were not able to stay around, they have had the benefit of your written testimony and they and their staffs will be taking it into account and look forward to working with the veterans oranizations on this construction aspect of the budget, as well as other areas.

Mr. Bilirakis.

Mr. **Bilirakis**. Thank you, Mr. Chairman.

Certainly these gentlemen are a part of the scene up here and they understand the demands in our schedules. They certainly don't see the lack of members being present as a lack of interest. While this is the only nonpartisan—I don't even like to say bipartisan—committee in the Congress, the veterans come first, regardless of party or whose party is in office at the White House, whatever the case may be.

I don't have any questions. You know, we oftentimes think and talk in terms of partnerships here, and usually we talk in terms of partnerships as being the private sector with government, or of volunteerism and that sort of thing, because there are so very many needs in our society. If we look strictly to the Federal Government to solve those needs, there just aren't enough dollars there. Money doesn't grow on trees, contrary to what a lot of people in other countries think.

For instance, I know that Florida does not have a State home, and we're generating an interest in one now. We are working with the new Governor. So basically, what I'm saying is that I concur with everything these gentlemen have said and what you have said, that certainly the VA's 5-year plan is completely out of line. There's no question about it. I think you know how this particular committee feels about all of that and there's no sense in repeating it.

But I think we would be foolhardy to just sit back—and I'm not for one moment insinuating that anybody is—to sit back and just say let the Federal Government do it all. We have got to concentrate on local facilities. Dr. Gronvall and Mr. Neumann made a comment about conversions. Well, we have got to take really serious looks at that. We've got to take serious looks at State homes, where you have the matching dollars concept.

I would ask merely of you gentlemen, and to the other veterans organizations, through your bulletins, through your networks and all of that, to help all of us to generate the grassroots interest. For instance, I assume we Members from Florida are going to really be putting pressure on the Governor for that State home in Florida. But if the interest and the pressure also comes from the grassroots veterans down there—whether it be the American Legion, the DAV, the VFW, et cetera—you can see how much more weight that would carry. So we would ask you to work with us, in a partnership, if you will, to try to accomplish this. The bottom line of it all is to have proper facilities for our veterans. If we can get them through a partnership-type of a thing here, rather than depending strictly on the Federal Government, that is still the bottom line.

I commend you for all your interest and your great work. Thank you.

Mr. PENNY. Thank you, Mr. Bilirakis. I thank our panel again for their presentation this morning.

We will call on the last panel of veterans organizations this morning. We have Frank DeGeorge and Kim Beasley of the Paralyzed Veterans of America, and David Gorman from the Disabled American Veterans. Welcome to the committee.

While you are coming forward, I want to assure you that your entire written text will be made a part of the committee record, and you are therefore free to proceed and summarize your testimony, as you wish.

I think we will take you in the order you have been listed. I would call on Mr. DeGeorge first.

STATEMENTS OF FRANK R. DE GEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; ACCOMPANIED BY KIM BEASLEY, ASSOCIATE NATIONAL SERVICE DIRECTOR; AND DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

STATEMENT OF FRANK R. DE GEORGE

Mr. DEGEORGE. Good morning, Mr. Chairman. Kim Beasley is accompanying me today. On behalf of PVA, we want to thank you for the invitation, and most especially the opportunity to present testimony here today.

I first would like to say, with all due respect to Mr. Chris Smith, who suggested that veterans organization speak first on the agenda, I think it is proper that we reinforce his concern by stating we do have the ear of the Veterans' Affairs Committee, no matter in which position we present testimony, and for that we're always grateful and will always be grateful. So thank you, Mr. Chris Smith, just the same.

Mr. Chairman, in the absence of a comprehensive system for assessing the total need for new, remodeled or renovated Veterans' Administration medical facilities, the Veterans' Administration has chosen to propose a modestly-increased budget figure for fiscal year 1988. As in years past, it is difficult for the PVA to comment on the adequacy of the construction budget request since a mechanism currently does not exist whereby total facility deficiencies and new requirements can be assessed as a basic line for speaking to the budget.

In response to Public Law 96-22, the Veterans' Administration developed a priority listing of ten VA Medical Centers it finds to be most in need of construction. This list, submitted to Congress annually since 1979, has little basis since the VA cannot demonstrate a comprehensive assessment of all medical facility construction needs. In addition, the Veterans' Administration prioritization methodology, which was developed in response to the directive contained in Senate Report No. 98-506 accompanying Public Law 98-371, is also seriously flawed. This methodology, which is to be utilized for assessing the system-wide priorities of the Veterans' Administration for construction, does not adequately address the comprehensive construction needs of the system. The intent of this directive was to structure a priority order whereby projects that will correct the most serious deficiencies will be developed first. The VA prioritization methodology fails to fulfill this intent since no comprehensive assessment of facility needs exists.

This sad truth underscores the urgent need for the timely and proper implementation of the core process recommendations identified in the Booz, Allen and Hamilton "Comprehensive Study of the Veterans' Administration Construction Process." Properly implemented, these much-needed procedural changes will allow decision makers to measure the impact of a $525.7 million construction budget on the total Veterans' Administration facility need.

The VA has recently initiated a pilot program to begin a facility planning process, one of the key recommendations of the Booz, Allen and Hamilton study. PVA's review of the pilot program's statement of task reveals that the most important aspect of the first core process recommendation has been seriously neglected. Specifically, a system for measuring and projecting total Veterans' Administration medical facility needs is noticeably absent. The Booz, Allen and Hamilton study identifies prerequisite steps in the form of computer system requirements before facility development plans are initiated.

The intent of the FDP pilot program is to access the adequacy of the FDP program methodology and to take corrective action. Yet, the results of the pilot projects will not be available to give substantive feedback to the 40 FDP projects anticipated in fiscal year 1988.

Last year, PVA testified before this committee that the implementation of the Booz, Allen and Hamilton core process recommendatons deserved careful scrutiny because those organizational components which have allowed the facility planning process to become so flawed have now been given the task of critiquing, interpreting and implementing the same. Our review of these efforts to date confirms that the VA simply has not kept abreast of current facility planning techniques, nor have they acquired or utilized the professional expertise necessary to perform the task.

Mr. Chairman, I notice my time is up. I will make one quick recommendation, if you will allow me.

Mr. Penny. Proceed.

Mr. DeGeorge. PVA does recommend to this subcommittee that immediate action be taken to provide appropriate oversight over

VA implementation efforts as it relates to the core process recommendations. Recognizing that the reorganization of the Veterans' Administration's construction program is principally driven by the Booz, Allen report, this reorganization and its relationship to the Booz, Allen Hamilton core process recommendations should be demonstrated to this subcommittee as well as to the veteran service organizations.

On that note, I would conclude our presentation and thank you once again.

[The prepared statement of Mr. DeGeorge appears at p. 116.]

Mr. **Penny**. Thank you. We will certainly give your recommendations every consideration.

Before I call on Mr. Gorman, I want to yield to counsel to ask one question.

Mr. **McDonell**. To either Mr. DeGeorge or Mr. Beasley, could you tell the committee how long the planning process normally takes, from inception to conception, for a medical facility in the VA, and could you give us an example of how long it takes with someone, say, like the American Hospital Association or one of the big medical facility people?

Mr. **Beasley**. Jack, I think in response to that we would have to glean the findings of the Booz, Allen Hamilton/RTKL study. They indicated as a minimum, once a project was identified as being needed, through construction and occupancy, you're looking at approximately 8 years.

Now, I would be guessing if I told you what the Hospital Corporation of America or Humana would do in that regard, but let me just take a ballpark figure. I believe it would be about 5 years. In fact, the recommendations of the Booz, Allen Hamilton report, if implemented properly, should realize at least, probably most effectively, a 3-year savings in that 8-year current process. So I think, properly implemented, the VA would realize a system that would come close to what the Hospital Corporation of America or some other organization like that would expect.

Mr. **McDonell**. Thank you.

Mr. **Penny**. Thank you.

We now call on Mr. Gorman from the DAV.

STATEMENT OF DAVID W. GORMAN

Mr. **Gorman**. Thank you, Mr. Chairman. I also would like to take the opportunity to express our appreciation for the invitation to testify today.

As you well know, Mr. Chairman, the VA's fiscal year 1988 program level request for construction is $525.7 million, approximately $449 million which will be devoted to the VA health care system.

While we do support full funding of the proposed construction program, we are nevertheless concerned not only with the quality of care currently being provided, but also about the VA's ability to meet the pressing demands being placed upon its health care system.

The DAV is concerned, as I know this committee is, Mr. Chairman, with how the VA will provide for the health care needs of the rapidly increasing aging veteran population. We know that greater numbers of elderly veterans are seeking nursing home care from the VA. Yet, of this medical construction budget, less than 1 percent, $4.5 million in the minor construction account, is being requested for nursing home care, bed conversion, renovation, or relocation. While more and more elderly veterans are seeking nursing home care from the VA, this construction budget reflects the Office of Management and Budget's policy which directs the VA to shift the responsibility for VA nursing home care to both State and community nursing facilities. As a result, all new VA nursing home care projects and new bed construction have been proposed to be cancelled.

Mr. Chairman, Public Law 99-166 mandated the VA to develop and submit to both Veterans' Affairs Committees an annual report and strategic plan on the construction, replacement, alteration and operation of each of the VA's medical facilities, to include any proposed changes, with justification, of the mission of VA medical facilities. Prior to today's hearing, Mr. Chairman, we were unaware of any such strategic plan being formulated by the agency. Yet, even in the absence of that plan, it is our understanding, as has been discussed earlier today, that decisions have been made to effectuate some significant mission changes at the VA Medical Centers in Big Spring, TX, Miles City, MT, Walla Walla, WA, and the closure for the New Bedford, MA outptient clinic.

Frankly, Mr. Chairman, it is our view that actions such as these seriously undermine this subcommittee's oversight role of the construction process and do effectively impede any congressional input into the agency's overall mission to provide quality health care services.

As you are aware, Mr. Chairman, the VA has long been involved, since early 1983, in the process of developing a prototype nursing home care unit. A successful completion of that concept would result in quality, timely, and cost-effective nursing home care facilities to help alleviate, as well as address the long-term care needs of aging veterans. Certainly, the DAV would support this initiative.

However, an audit of the prototype nursing home care unit was completed by the VA's Inspector General, and in a report dated January 3, 1986, it was stated—and I quote: "The VA has not yet accomplished its major program initiative of developing a nursing home care unit prototype that provides quality, timely, and cost-effective facilities to meet the long-term care needs of aging veterans."

Mr. Chairman, the identified weaknesses in the VA construction process relating to that nursing home care unit are, in our view, valid and point to the larger question of the agency's overall construction process and the organization now in place to manage that vital program.

We would be less than candid if we did not relate our continued concerns regarding the reorganization of the Office of Construction. In our opinion, the current structure eliminates any central control function of the Department of Medicine and Surgery and effectively removes the Chief Medical Director and his staff from any vital planning efforts. We would encourage the agency to move forward quickly toward the goal of establishing an appropriate design and approval process for its construction program. This will be possible only when all interested parties are actively involved in the needs assessment and initial planning process.

In conclusion, Mr. Chairman, we wish to applaud the efforts of this committee in your recent report to the Budget Committee, which recommended continued funding for four new nursing home care units. Additionally, the DAV is in total agreement with the committee's proposal that the VA cease to look to the private sector to provide the bulk of nursing home care services to disabled veterans. With a number of States seeing a moratorium on new nursing home care bed construction, we are not at all optimistic that the private sector has or will have in the near future the capability to meet the needs of disabled veterans. Thus, in our opinion, any increased reliance by the VA on the private sector to provide extended care services to disabled veterans is certainly ill-fated and short-sighted.

Mr. Chairman, that concludes my testimony. Thank you again.

[The prepared statement of Mr. Gorman appears at p. 120.]

Mr. PENNY. Thank you for your presentation. We appreciate both veterans organizations making specific reference to the nursing home care issue.

Mr. Gorman, in your testimony you talk about the experience you've had with the prototype nursing home plan. Can you give a little more information to the committee about the role the DAV has played in trying to work with the VA over the years to get that in place, maybe some additional observations as to why you think it has taken so long?

Mr. GORMAN. Mr. Chairman, the last part of your question, I really have no idea why it has taken so long.

As far as our involvement, I believe in the infancy of this idea, of this initiative, the service organizations were briefed by the VA. My long-term memory doesn't tell me exactly when that was, however. Since that time, we virtually have not heard any mention of the prototype from the VA in any type of a formal briefing session, requesting input or suggestions, reviewing plans or what they have come up with, until I believe late January of this year. At that point in time the prototype had certainly gone through a lot of revisions, totally different than what we had originally been briefed on.

We are hopeful at this point that that initiative is ready to move forward. We understand it is to be used in Amarillo, TX for the first one. We certainly think it's a credible idea and one that will help to move the agency forward to do what they should be doing, in our opinion, as far as extended care.

Mr. PENNY. In your testimony you indicated that DM&S was not involved at the front end in the planning process and that you believe they ought to be. I think many of us in the committee also think they ought to be, in terms of laying out what the health care needs are and what what the purpose of the VA is. But instead, you seem to indicate that the construction budget is driven by decisions at another level. I heard the testimony from Dr. Gronvall this morning that he felt they were involved in every step along the way.

On what basis do you make the charge that the medical concerns are not being adequately taken into account in their construction budget?

Mr. GORMAN. I think we're seeing that from counsel's earlier question this morning regarding the Duluth situation, and where DM&S has identified where the need is and where the greater population of veterans are, and where the ultimate decision has been made to locate that outpatient clinic.

I think a lot of our testimony is driven, and a lot of our views are driven and reinforced, by basically what happened during the implemention, or just prior to the implementation, of this reorganization last year. At that point in time there was a lot of concern by a lot of folks, directly involved in health care delivery, that they would, in fact, be excluded from the continued planning and implementation process of the construction needs.

It is our view that, when we talk about construction of VA medical facilities, what we're really talking about here is not brick and mortar construction, but the end result of providing medical care to disabled veterans based on the users and the professionals, the utilization of those facilities. That is basically where our concern lies.

Mr. PENNY. Thank you for your response.

Mr. Beasley, do you want to speak to the prototype nursing home care issue.

Mr. BEASLEY. Yes, if I could. We did receive a briefing from the VA, the veterans service organizations did, I believe in January. What they presented was an end product which, upon reviewing, we thought was minimally satisfactory. But we submitted written comments to the VA regarding the nursing home prototype specifically relating to the Inspector General's report and his recommendation. PVA contends that they didn't follow the recommendation adequately because he specifically states that the VA should develop a process to ensure that something like this won't happen again. To take 3, 3½ years to 4 years to design a building just isn't right.

What went wrong? The thrust of the IG's report was to tell the VA, listen, let's develop a process, let's involve all interested parties to make sure we can come up with a prototype nursing home or, for that matter, a prototype of any type. So that was our specific comment on that. I think a lot of our concerns were brought to resolution, especially as they related to accessibility for that population.

Mr. PENNY. Thank you for your testimony.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. DeGeorge and Mr. Beasley. Mr. Gorman, as part of his testimony said that the VA's proposal to convert 282 hospital beds to nursing home care beds is supported by them, and it is also supported by your organization, right? I would gather by the other organizations, also, right?

Mr. DEGEORGE. Yes.

Mr. BILIRAKIS. We're all just saying it's not enough, but we certainly support the conversion.

Mr. DEGEORGE. Correct.

Mr. BILIRAKIS. I think that's true, isn't it.

The January meeting that you both referred to, was that limited strictly to the prototype nursing home facilities?

Mr. BEASLEY. Yes.

Mr. BILIRAKIS. How often does something like that take place, where there are briefings and discussions between the VA and the veterans organizations?

Mr. GORMAN. Mr. Bilirakis, I would like to respond to that.

As far as overall briefings by the agency, they seem to occur frequently enough, on a variety of issues, not including the Office of Facilities. I, unfortunately, was not at that January meeting. Another member of our staff was, but I can't respond to your question about being exclusively devoted to the prototype——

Mr. BILIRAKIS. Mr. Beasley was?

Mr. GORMAN. Yes.

Mr. BILIRAKIS. Is that right?

Mr. BEASLEY. Yes.

Mr. GORMAN. But formal, independent briefings by the agency, as far as the Office of Facilities, on the reorganizational process, to my knowledge, haven't occurred.

Mr. BILIRAKIS. They have not occurred.

Mr. GORMAN. Not to my knowledge.

Mr. BILIRAKIS. Well, I find it very favorable that Dr. Gronvall is still here, and Mr. Neumann and Miss Livingstone. You know, they just haven't testified and then walked out. They are interested in your testimony. I don't know whether they received copies of it or not. I think that's very favorable.

But it seems to me that we're all working for the same thing, and I'm convinced the VA people are, also. Hopefully, that this is going to be a continuing thing, not just briefings, but actually sitting down around the table and trying to work things out, realizing that the VA ~~is somewh~~at "limited", if you will, by people in OMB, et cetera. I would hope more of that would take place. I would think a lot more could be accomplished, because you all represent the grassroots, and none of us know it all. We are all certainly open to further knowledge.

Yes, Mr. Beasley.

Mr. BEASLEY. Mr. Chairman, if I could offer a further comment on that, there is a monthly meeting of the veterans service organizations with the CMD, Dr. Gronvall, and that is very helpful. I think with the recent change, where a significant part of DM&S, as it relates to facility planning, has been given to the Office of Facilities, we would like to see another forum with that element of the VA.

I think the Office of Facilities needs to demonstrate that their reorganization is clearly tied to the Booz, Allen Hamilton report. PVA is concerned that it hasn't been. We know that the reorganization is driven by that report. I think this subcommittee, the PVA and the other service organizations deserve that opportunity to see exactly how it responded to primarily the core process recommendations.

Mr. BILIRAKIS. As far as I'm concerned, Mr. Chairman—and you're running the meeting—but if there is anybody in the audience from the VA who would like to add anything to this specific discussion or respond to it, I certainly would welcome it.

Mr. GORMAN. Mr. Bilirakis, if I may just add one thing to what Mr. Beasley stated about this monthly CMD and veterans service organizations meetings, they are helpful. They are helpful to the extent that the VA has the opportunity to talk to us and communicate with us about what issues are going on, the current status of them, as well taking any suggestions we might have.

I think, to Dr. Gronvall's credit, these meetings have gone on more or less the same way since I've been attending them. Dr. Gronvall came out just recently and surveyed, in the form of a questionnaire, the various organizations, asking for any changes in format, suggestions that we think would make them more attentive and more meaningful from our perspective. For that, we certainly thank Dr. Gronvall.

Mr. PENNY. Miss Livingstone would like to comment.

Ms. LIVINGSTONE. Thank you, Mr. Chairman.

We would welcome any type of regular formatted meetings with the veterans service organizations. We have provided briefings as a part of the Chief Medical Director's monthly briefing, both on the reorganization and on a number of other issues. But if a separate format is needed, with just Office of Facilities issues, on a regular basis would be helpful, we would welcome that opportunity.

Mr. BILIRAKIS. Is this something that you could initiate, conceivably?

Ms. LIVINGSTONE. Yes, sir. We would be glad to host it and, based on the feedback, could determine with the veterans service organizations the frequency of the meetings. We would be delighted to.

Mr. PENNY. I think that would be very helpful and the committee certainly wants to facilitate that kind of dialogue.

The time of the gentleman has expired, and the time of the committee has expired. I want to thank the panelists for their presentations. I think it has been a productive morning.

The committee stands adjourned.

[Whereupon, at 1:47 p.m., the subcommittee was adjourned.]

APPENDIX

STATEMENT OF THE
HONORABLE G. V. (SONNY) MONTGOMERY
CHAIRMAN
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
AT THE HEARING ON
VETERANS ADMINISTRATION
MEDICAL FACILITY CONSTRUCTION
MARCH 11, 1987

THE SUBCOMMITTEE WILL COME TO ORDER.

THE TOPIC OF THE HEARING TODAY IS CONSTRUCTION OF MEDICAL FACILITIES BY THE VA. THE VA HAS REQUESTED FOR FISCAL YEAR 1988 $525.7 MILLION FOR THE AGENCIY'S CONSTRUCTION PROGRAM. OF THAT AMOUNT, $394 MILLION IS FOR THE MEDICAL CARE MAJOR CONSTRUCTION PROGRAM AND $121 MILLION FOR MINOR CONSTRUCTION.

THE MOST IMPORTANT ASPECT OF THE

CONSTRUCTION PROGRAM IS ITS IMPACT ON THE FUTURE ABILITY OF THE VA TO DELIVER HEALTH CARE.

THE DECISIONS MADE DURING THIS SESSION OF THE CONGRESS WILL SET THE CAPACITY LIMITS FOR MEDICAL CARE IN VARIOUS LOCATIONS AROUND THE COUNTRY FOR MANY YEARS TO COME.

IN CONSIDERING THIS CAPACITY ISSUE, WE WILL TALK IN TRADITIONAL TERMS OF ACUTE CARE, LONG TERM CARE AND OUTPATIENT CARE. AND YET, WE WILL ALSO BE TALKING ABOUT CHANGE. THERE IS CHANGE IN THE NEEDS OF VETERANS AS THEY GROW OLDER. THERE IS CHANGE IN THE WAY MEDICINE IS BEING PRACTICED WITH SOME SHIFTS TO OUTPATIENT SETTINGS FOR CERTAIN SERVICES THAT PREVIOUSLY REQUIRED INPATIENT STATUS. WE WILL TALK ABOUT CONVERSION OF BEDS TO LONG TERM CARE USE. WE WILL TALK ABOUT THE VA'S

POLICY OF INCREASED DEPENDENCE ON COMMUNITY NURSING HOMES AND ON STATE VETERANS HOMES.

AS IF ALL OF THIS WERE NOT ALREADY SO COMPLICATED, WE MUST CONSIDER THE NATIONAL PICTURE AS WELL. THAT MEANS TO THINK ABOUT CONTROLLING EXPENDITURES TO AID IN DEFICIT REDUCTION AND IT MEANS TO REMEMBER OUR NATION'S PLEDGES TO OUR VETERANS.

IN ORDER FOR US ON THE COMMITTEE TO DO OUR JOB AND, IT SEEMS TO ME, IN ORDER FOR THE VA TO DO ITS JOB FOR THE FUTURE OF VA HEALTH CARE, THERE MUST BE PLANNING FOR CONSTRUCTION. THE CONGRESS HAS MANDATED TWO DISTINCT REQUIREMENTS. ONE IS A FIVE-YEAR PLAN FOR CONSTRUCTION, REPLACEMENT, OR ALTERATION OF MEDICAL FACILITIES. THE OTHER IS A FIVE-YEAR STRATEGIC PLAN REGARDING MISSIONS OF VA FACILITIES.

THESE TWO REPORTS WERE DUE IN JUNE OF 1986. WE RECEIVED THEM ONLY TWO DAYS AGO; THAT IS FULLY NINE MONTHS LATE. FURTHER, THE TWO REQUIREMENTS WERE LUMPED TOGETHER INTO ONE LARGE DOCUMENT. IN THE AMOUNT OF TIME AVAILABLE TO ME TO READ IT SO FAR, IT APPEARS THAT NEITHER PLAN WAS COMPREHENSIVELY ADDRESSED.

DURING THAT DELAY BETWEEN THE DUE DATE FOR THE PLANS AND THE RECEIPT OF THE SINGLE DOCUMENT, WE IN THE CONGRESS WERE PRESENTED A PROPOSED VA BUDGET FOR FISCAL YEAR 1988. WE MET OUR DEADLINE FOR MAKING RECOMMENDATIONS TO THE BUDGET COMMITTEE. BUT WE DID IT WITHOUT ANY INFORMATION FROM THESE TWO MAJOR PLANNING TASKS. THE TARDINESS OF THE VA HAS HINDERED OUR WORK AND I AM SERIOUSLY DISAPPOINTED. I HAVE EVERY HOPE THAT NEXT

YEAR, NOW THAT THE NEW PROCESS OF THE VA TO DEVELOP FACILITY PLANS IS SET, THE PLANS WILL BE COMPLETE AND THEY WILL BE TIMELY.

IN ADDITION, I HOPE TODAY TO REASSURE MYSELF THAT THE RECOMMENDATIONS OF THE CHIEF MEDICAL DIRECTOR WILL IN FACT BE CONSIDERED BY THE ADMINISTRATOR.

THERE ARE SEVERAL MEMBERS OF CONGRESS WHO HAVE TAKEN TIME FROM THEIR SCHEDULES TO BE PRESENT WITH US TODAY TO PRESENT TESTIMONY ON SPECIFIC PROJECTS OR CONCERNS OF THEIR DISTRICTS. INDEED, OUR FIRST WITNESS TODAY IS MY FRIEND JIM FLORIO WHO IS A MEMBER OF OUR FULL COMMITTEE.

JIM, PROCEED WHEN YOU ARE READY.

STATEMENT OF HONORABLE MARVIN LEATH
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS' AFFAIRS COMMITTEE
MARCH 11, 1987

Mr. Chairman, I appreciate the opportunity to testify here before you today regarding Project #549-031 at the Dallas VA Medical Center.

Mr. Chairman, the Dallas VA Medical Center is in critical need for renovation and expansion due to major space deficiencies and design imposed functional obsolescence. These deficiencies impact negatively upon the ability of the Center to provide the very best possible care for veterans. The newest patient building was built in 1952 to support 500 beds. That building is now supporting 800 beds. The eight operating room suites are of 1940's design. So, the need for the clinical addition has been critical for a long time.

The Dallas VAMC has a 28-county primary service area which includes 473,000 veterans and this number has increased yearly. There has been a substantial increase in requests for appointments for new patients. Also, the number of outpatient visits has risen from 192,000 in 1984 to over 283,000 in 1986. The Center's operating rooms are utilized at maximum capacity and yet there are backlogs for urological, ophthamologic and thoracis surgical cases ranging from a month to six weeks. The operating room themselves are small and cramped by today's surgical design standards. The proliferation of high technology equipment that makes so many surgical procedures possible today was not even dreamed of when the suites were designed. In addition, sufficient storage capacity is also needed to accommodate the growing number of equipment items supporting today's surgeons. The provision of a totally new expanded operating suite is the number one priority need met by this project.

The first request for relief was made in 1972. The project was proposed and developed to meet the major construction needs of the Center and encompassed the addition of approximately 500,000 gross square feet of floor space and the total renovation of Building 2, which houses the main medical and surgical inpatient facility. A 30-bed long-term Spinal Cord Injury (SCI) Unit and a 30-bed acute-sustaining SCI Unit are also included in the construction plan.

The facility has been cited by the VA as the most active Medical Center in the treatment of spinal cord injury patients to not possess a dedicated spinal cord injury facility. The special clinical and facility needs of these patients will be met by the 60-bed SCI unit.

The VA has already spent approximately $3.5 million to develop both the concept and the preliminary plans for this project, which began in 1983. The goal was to complete the preliminary plans in FY 85 and to develop the final working drawings during FY 86. Construction was initally planned to begin in FY 87. However, based on the VA budget that went forward and at the discretion of OMB, all funds for working drawings were knocked out of the FY 86 budget. Likewise in the FY 87 budget the project was submitted by the VA to OMB for funding. Again, significant cuts by OMB in the VA construction appropriation for FY 87 resulted in the project being pushed back to FY 88 for potential working drawing funding. Once funded, Dallas would still face at least a year to complete the design work. Construction, once initiated, would require four years to complete. These delays mean that we would have to shift our acceptance of these upgraded facilities from 1991 to 1994. Also, it would ignore the fact that the current economy has reduced construction costs.

The need for this project is evident and it has been recognized by the VA as one of the ten most needed projects. I urge you to include in the FY 88 budget the $14.3 million for design funding.

STATEMENT OF CONGRESSMAN MARTIN FROST

BEFORE

THE VETERANS' AFFAIRS SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

MARCH 11, 1987

MR. CHAIRMAN, the issue I would like to bring before you today is of importance to the people of my district and North Texas. It concerns the need for the expansion of the Dallas VA Medical Center. This 800 bed hospital has needed renovation and expansion since 1972. To alleviate the hospital's space deficiencies and functional obsolescence, the addition of 500,000 gross square feet of floor space and the renovation of the main medical and surgical inpatient facilty has been proposed. These improvements are necessary to provide better care to the more than 470,000 veterans in the 28 counties in North Texas served by the hospital.

A key element of the proposed improvements is the construction of a Spinal Chord Injury Unit with 30 beds for long term care and 30 beds for acute/sustained care. The Dallas VA Medical Center has been cited by the VA as the most active Medical Center, without a spinal care unit, to be responsible for the treatment of spinal care patients. The absence of a spinal care unit is causing a hardship on the many veterans in the area with spinal chord injuries, as they must now travel to Houston or Memphis for treatment.

Planning for the proposed clinical addition and renovation, Project 549-031, is currently on hold. Initial planning efforts started in 1983 with the development of a construction concept. Preliminary design plans were initiated in 1984, with all preliminary design work being completed in the summer of 1985. The Veterans Administration has expended approximately $3.5 million to bring the project to this point.

Originally a goal was set to complete all preliminary plans in FY 85, to develop the final working drawings during FY 86, and to begin construction in FY 87. To that end approximately $15 million was requested in the FY 86 Veterans Administration budget to fund the final working drawings. Unfortunately, this funding was eliminated from both the FY 86 and FY 87 budgets by the Office of Management and Budget.

Now I have learned that the VA has not even requested design funding in FY 88. If design funding is not provided in FY 88, construction on this project will begin, at the earliest, in the nineties. While it is recognized that the need for a balanced federal budget requires sacrifices, delaying the completion of this project will not only deprive veterans of needed health care, but will also increase the project's ultimate cost.

The need for this project is evident, and the VA has recognized its importance by including it on the Ten Most Needed Projects list. I urge you to include in the FY 88 budget the $14.3 million for design funding that will keep this project on track, so that the veterans in North Texas, especially those with spinal chord injuries, can have the care they deserve.

DOUG WALGREN
18TH DISTRICT PENNSYLVANIA

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Washington, D.C. 20515

Dear Mr. Chairman;

I am writing to underscore the importance of continuing funding to replace the Veteran's Administration facility in Aspinwall, Pennsylvania. This project has been supported by this Committee in the past and deserves continued support.

Pennsylvania has one of the highest percentages of veterans in the nation. The estimated 425,000 veterans of Western Pennsylvania deserve treatment at a facility that has modern equipment and is in good condition. The current facility at Aspinwall has been called by the VA one of the four hospitals in the U.S. most in need of replacement. Constructed in 1925, the building is not in compliance with local health and safety building codes. For this reason, and to meet a growing demand for bed space, this Committee voted to replace the old hospital with a new 240 bed complex.

I commend the Administration for requesting $5.7 million to complete the design phase of the project in fiscal year 1988. I hope the committee can support this amount as well as the estimated $41.85 million for construction in the following years.

Sincerely,

Doug Walgren
Member of Congress

DW/nes

Special thanks!

Testimony of Representative Tony P. Hall
on fiscal 1988 Veterans Administration Medical Construction
before the Subcommittee on Hospitals and Health Care
House Committee on Veterans Affairs
March 11, 1987

Mr. Chairman and members of the Subcommittee, thank you for giving me the opportunity to testify on the Veteran's Administration medical construction authorization requests for fiscal 1988.

I am testifying in support of construction funds for a new hospital building at the Dayton, Ohio Veteran's Administration Medical Center within the 3rd Congressional District which I represent. The administration's budget request includes $74.1 million for the project. Last year, Congress approved $8.4 million to design the building.

When completed, the building will accommodate medical, surgical, and psychiatric beds, as well as selected diagnostic treatment and support functions.

The building will replace Brown Hospital, the existing acute care hospital building, which was constructed in 1931 and has never undergone any major renovation. The proposed hospital is the result of a planning process which began in 1979 when it was determined that Brown Hospital was inadequate to meet the medical needs of the veterans.

On several occasions, I have visited Brown Hospital, and I can assure the members of this Subcommittee that the facilities do not meet my expectation for the high quality, modern service to which I believe our veterans are entitled.

Most noticeable to me is the lack of privacy for many of the beds. The intensive care units are not designed to current standards which permit medical personnel to closely watch the patients. Corridors are narrow, and there are too few exists. The building is not seismic resistant.

The Joint Commission on Accreditation of Hospitals and other accrediting survey teams have determined that Brown Hospital has serious space, functional, structural, fire, and safety deficiencies.

These deficiencies are too large and too numerous to be corrected with rennovations, thus requiring the new building.

The entire Dayton community has long waited for the construction of a facility to replace Brown Hospital. The Dayton Area Chamber of Commerce in particular has championed this project, and many of its members have come to Washington to demonstrate their personal support. We are all anxious to see it move ahead on schedule.

The Dayton VAMC is the third oldest veterans facility in the nation. It serves a primary service area of 28 counties in Ohio and one county in Indiana with a total of 387,000 veterans. It is a major teaching hospital for the Wright State University School of Medicine, providing training for over 100 residents and 200 medical students.

I urge the members of the Subcommittee to approve the construction funds for the Dayton VAMC.

STATEMENT SUBMITTED BY ROBERT ROUTH, JR.
NATIONAL PRESIDENT OF THE BLINDED VETERANS ASSOCIATION (BVA)
SUBMITTED TO THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
U.S. HOUSE OF REPRESENTATIVES
RE: VA MEDICAL CONSTRUCTION AUTHORIZATION REQUEST FOR FY 1988

Mr. Chairman and members of the Subcommittee, the Blinded Veterans Association (BVA) appreciates this opportunity to submit a written statement for the record of the Subcommittee on Hospitals and Healthcare on March 11, 1987, regarding the Veterans Administration's (VA) Construction Budget for FY 1988. The BVA has two concerns in addressing VA construction projects in FY 88, future construction, or any renovation projects it might undertake in its facilities.

First, the BVA is concerned that any project be cognizant of accessibility for the blind as well as other disability groups. It is important that wherever possible, facilities should be constructed to accomodate the needs of blinded veterans. This does not require major design changes or architectural modifications, but does require something as simple as using raised numbers on rooms within the facility, enabling blinded veterans or those with severe visual impairments to locate rooms independently. When large raised numbers are used, the totally blind can tactily determine the numbers and those with partial vision may be able to see the raised numbers when trying to locate a particular room. Similarly, elevators should be accessible to the blind by having operating panels marked both in braille and raised numbers. It would also be most helpful to have some kind of bell system which would indicate which direction the elevator was going. In terms of the total construction budget for a medical center, this kind of effort in behalf of accessibility for blinded veterans would be insignifcant.

The other concern the BVA has regarding construction does not apply directly to the FY 88 budget proposals, but more realistically to future budgets. We bring it up here in order to stimulate interest and initiate planning in this and future budget considerations. For the past several years, the BVA has recommended to the VA the need for a new Blind Rehabilitation Center to be constructed at the VA Medical Center in Dallas, TX. This proposal was initiated by the director of VAMC Dallas and submitted through the Medical District 20, in compliance with the Medical District Initiated Planning Process (MEDIPP). The proposal moved successfully through this process and was approved not only at the district level, but at the regional level as well (1984). The response to the district from Central Office was that there were no funds available for such a project.

The BVA respectfully requests this Subcommittee and the Full Committee to recommend the inclusion of sufficient funds in this or future budgets for the Dallas Center. There are currently four blind rehab centers in the U.S. serving all blinded vets. They are The Western Blind Rehab Center, VAMC Palo Alto, CA; The Central Blind Rehab Center, VAMC Hines, IL; The Eastern Blind Rehab Center, VAMC Westhaven, CT; and The Southeastern Blind Rehab Center, VAMC Birmingham, AL. Each of these centers maintains waiting lists for admission to their respective programs and veterans are required to wait 3 to 4 months and sometimes even longer. In the state of Texas alone there are approximately 2,200 blinded veterans known to the VA Visual Impairment Services Team (VIST) Program, and 60% of these have not attended blind rehabilitation for a variety of reasons, including long distances they would have to travel to the existing blind centers, cultural differences, as well as climatological differences they would encounter at those facilities. This number does not include all blinded vets who are eligible for blind rehabilitation. Eligibility for VIST is narrower than for blind rehab itself. In addition to those blinded veterans already identified and known to the VA, the VA and other organizations estimate that there are an additional 4,000 blinded vets in Texas who may be in need of blind rehab services.

Those states immediately surrounding Texas, Louisiana, Arkansas, Oklahoma and New Mexico have identified approximately 1,200 VIST eligible blinded vets and estimate another 2,000 to 2,500 blinded vets in those states. Further, we are all well aware of the migration of people, particularly older Americans to the southwest and sunbelt states. This trend is expected to continue and this can only mean increasing numbers of blinded veterans requiring services.

In the long-term, the construction of a new blind rehab center in Texas can prove cost effective for the VA. We have indicated in previous testimony the need for adequate services for blinded vets in order for those individuals to make positive adjustments to sight loss and acquire the skills necessary to enhance their ability to function independently. The greater the degree of independence, the less these veterans will have to depend on the VA for care. Without such skills, these veterans might end up in

VA facilities only because they are blind. The need for rehab training exists not only for those veterans who are newly blinded due to the aging process, but also for blinded vets who are getting older. This latter group, although they may have had blind rehab in the past, may need a refresher course in order to maintain independence and in some cases, relearn skills they have not had to use. Frequently blinded vets who were married were not required to cook for themselves, but when their spouses die, they do need such skills in order to continue living alone. Blinded veterans do not want to become a burden to their families because of their blindness and similarly we do not want to be a burden on the VA and the taxpayers of America because of a lack of independent living skills.

Mr. Chairman, thank you for this opportunity for the BVA to express its views on VA construction and as always we stand ready to work with this committee on these issues.

BLINDED VETERANS ASSOCIATION
1726 M STREET NORTHWEST SUITE 800 • WASHINGTON D C 20036 (202) 223-3066

RESOLUTION 22/86

WHEREAS, there is a current identified population of 2187 VIS eligible blinded veterans in Texas, this number does not reflect those visually impaired veterans eligible for blind rehabilitation, AND

WHEREAS, some 60% of those identified blinded veterans have not attended rehabilitation because of distance, cultural differences, health climate, etc., AND

WHEREAS, those who have attended can, if there is specific need, return to rehabilitation, AND

WHEREAS, figures from various national agencies and organizations indicate an estimated additional 4000 blinded veterans in Texas bringing the population to over 6000, over 50% being over the age of 65, AND

WHEREAS, the surrounding states of Arkansas, Louisiana, Oklahoma, and New Mexico have an identified population over 1200 and an additional 2000 to 2500 estimated, AND

WHEREAS, the Southwestern part of the U.S. has the fastest growing population, consequently the blinded veteran population will also grow, AND

WHEREAS, Dallas VAMC has presented a proposal to District 20 Planning Committee for a Blind Rehabilitation Center, which was approved July 23, 1984, THEREFORE BE IT

RESOLVED, that the BVA supports such action in order to serve the blinded veteran in a broader and more expeditious fashion.

STATEMENT OF HON. JAMES. J. FLORIO
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS AFFAIRS COMMITTEE
MARCH 11, 1987

Mr. Chairman, I appreciate the opportunity to testify here before you today at this hearing on the Veterans Administration medical construction request.

Mr. Chairman, permit me to relate to the Subcommittee the history of the Veterans Administration health care plans for Southern New Jersey. Three years ago you visited Southern New Jersey and you spoke at a meeting of several hundred state veteran leaders and told them that you would help us obtain better health care if the facts proved that we needed it.

Mr. Chairman, you now know what we in New Jersey have long known. Not only do the facts prove that an out-patient facility is desperately needed in Southern New Jersey but with a continuance of the population trends in the area the time is not far off where we may be asking for additional services. We are quite simply being besieged and we need help. On behalf of the veterans of South Jersey, and the several hundred who listened to you that day three years ago, I want to thank you for keeping your promise and helping us today.

Let me begin a short history for my colleagues of what we have been faced with in Southern New Jersey. I represent the First District of New Jersey which, for those of you not familiar with the area, is that part of New Jersey just across the Delaware River from Philadelphia. Two counties, Camden and Gloucester, are included in my District. Congressman Bill Hughes represents four counties, Salem, Atlantic, Cumberland and Cape May.

The VA has long recognized that they have a glaring weakness in health care delivery in Southern New Jersey. In the late 1970s a major VA Medical Center was planned for Camden, New Jersey. As the project unfolded land was purchased, designs approved and several homes actually razed in preparation for the hospital's construction. Finally, it seemd we would have adequate care for the hundreds of thousands of veterans to be served by the hospital.

The hospital was cancelled in 1981 following the installation of the new Administration. The reaction among New Jersey veterans, after having their hopes raised to such heights, when faced with the realities of the existing situation was one of outrage.

Following the cancellation of the Camden VA Hospital we soon learned of a new direction which the VA was taking in regards to health care. No longer would the VA construct large, downtown, medical centers at great expense. Instead the VA would establish "satellite out-patient facilties" which would orbit around those large medical centers. Veterans would be able to receive therapy, physical rehabiliation, examinations and treatment as well as access to the VA pharmacy. More serious cases would be sent to the major medical center. The idea seemed like a good one given the realities of the budget situation which was growing worse on a daily basis.

Following the new policy direction the VA instituted something called the Medical District Initiated Program Planning system. Termed MEDIPPs, the system was a mechanism which projected the medical needs of the VA for years to come. It was a computer based analysis which examined all demographic data available and evaluated the construction, medical service and needs of the VA in that geographical area. If the MEDIPPs plan called for an out-patient facility in Southern New Jersey it would go a long way towards getting some action for our area.

The 1984 MEDIPPs plan, released in December of 1984, ranked the 61 counties encompassed by Medical District IV in terms of need regarding out-patient needs. Of the top four counties from the entire district three of the four were the New Jersey counties of Ocean, Atlantic and Monmouth -- three New Jersey counties which lie contiguously along the Jersey Coast.

The medical evidence was clear. The southern part of New Jersey was being inundated by an influx of older veterans retiring from Northern New Jersey and New York and moving to communities in the less developed parts of Southern New Jersey. Not one but two out-patient facilities were probably justified by the VA numbers. Finally, we believed some action would be taken.

Thirty months have passed since that MEDIPPs report was made known to us. In that time we have seen the passage of the Gramm-Rudman bill which effectively stalled any VA plans for New Jersey. Fully 40% of the VA capital construction budget was cut by Gramm-Rudman. For those who may have felt that South Jersey would escape the Gramm-Rudman "meat cleaver" they soon learned that they were very wrong. The veterans continued to suffer as the effects of Gramm-Rudman were felt throughout the entire VA.

Last month the VA presented the FY 1988 budget to this committee. That budget included no specific funding for an out-patient facilty in Southern New Jersey. Many of you may have been present at the hearing on February 3 when VA Administrator Turnage offered testimony before the full committee. I questioned General Turnage as to the plans of the VA for Southern New Jersey. He responded that although specific funds were not in the budget for a South Jersey clinic that work was indeed proceeding ahead within the agency.

General Turnage mentioned that the VA was developing a plan which would allow the agency to enter into a long-term lease with a private contractor or developer to renovate an existing structure to be used for a clinic. Permit me to quote from a letter I have received from General Turnage which addresses this point.

> "If the result of the analysis indicate that leasing the facility is appropriate, it is anticipated that the lease award will be made during FY 1988. Following award of the lease, it is anticipated that approximately 10-16 months will be required to construct or renovate for VA lease and actual acceptance of the facility would not occur prior to FY 1989."

Mr. Chairman the purpose of this laborious review of the Southern New Jersey situation is to point out quite simply that we have had more than our share of proposals and plans from the VA. Six years have passed since the Camden Hospital was cancelled. Those veterans whom it was intended to serve have become six years older and more and more of them are developing serious medical problems.

General Turnage's words are hopeful. I would like to insure that finally, now that we are in a position to do so, that we make sure that those words become reality. The VA claims that they intend to establish a facility in Southern New Jersey. Let us require them to do so. Now.

The leasing mechanism which they claim to utilize for establishment of the facilty is already built into their operating budget. It will not require any additional funding. All it will require is that we direct the Administrator to establish an out-patient clinic in Southern New Jersey. This language alone, if carried through the Appropriations Committee cycle will help us greatly.

Mr. Chairman, the entire New Jersey Delegation has cosponsored a bill which would force the VA to establish this facility. My colleague from New Jersey, Chris Smith, and I have worked long and hard on this issue. Our work together indicates that this is a bi-partisan effort. Thousands of veterans are being neglected. We feel that now is the time to act. Any further delay cannot be justified. If we don't act now and if we cannot keep this language in the VA budget throughout the appropriations hearings then I think that we had better begin examining this issue in a different light.

Too many have suffered for far too long while others have told us that help is imminent. Our patience and the patience of thousands of New Jersey veterans has it's limits. But more importantly we want to know the truth. Either establish the clinic or don't establish it -- but please don't lead us down a path which allows false hopes. None of us can sustain another cycle of heightened expectations and dashed hopes.

I thank the Subcommittee for it's own considerable patience in listening this long, confusing, story. Thank you for the help you will give us.

Statement of Congressman Christopher H. Smith
Subcommittee on Hospitals and Health Care
Committee on Veterans Affairs
March 11, 1987

MR. CHAIRMAN, I come before this Committee about a subject that has been discussed many times and supported by the full committee: the establishment of a VA outpatient clinic in central or southern New Jersey.

As you know Mr. Chairman in the 99th, I introduced legislation to direct the Administrator of the VA to establish an outpatient clinic in the central or southern region of New Jersey. Last year, the full committee agreed to attach the language of my bill as an amendment to the Veterans Health Care Amendments of 1986 (H.R.4623). The full House subsequently adopted the same. The Senate unfortunately dropped my amendment in conference. Mr. Chairman, I have again introduced my bill in the 100th Congress and am pleased to have the support of Mr. Florio and the rest of the New Jersey delegation.

For many years now, the VA has been aware of the vital need to establish a facility to serve the nearly 1 million veterans in the State of New Jersey. In fact, the VA in its own MEDIPP study, indicated that the establishment of a satellite outpatient clinic in New Jersey is the highest priority within the entire Medical District IV. The VA minimum threshold to establish a satellite out-patient clinic is 15,000 service-connected visits per year. In Ocean County alone, the VA estimates that a clinic would receive 52,000 such visits per year - well over three times the minimum requirement.

Last year, I was assured by officals of the VA that a New Jersey outpatient clinic would be included in the FY 1988 budget request. It was not. About a month ago, the VA provided me with a schedule of dates for the completion of the clinic. Mr. Chairman, according to this schedule, the economic cost analysis for the clinic was to be completed by the end of February. It is now approaching the middle of March and, to my knowledge, the economic cost analysis is still not completed.

I understand delays, Mr. Chairman. But given the long history of delays on this project, the time has come for additional action by the committee to ensure that this desperately needed clinic becomes a reality.

Mr. Chairman, in order to lock this clinic into the FY88 VA Budget, I will again offer my bill as an amendment to both the VA Medical Construction Budget Resolution and to the relevant appropriation bill. I look forward to your support.

The veterans of my home state have been waiting for an outpatient clinic for too long. It is difficult to imagine how the need for outpatient care could be any greater than in New Jersey. Veterans in the southern regions of New Jersey currently must travel either to the Philadelphia VA hospital or to the Wilmington, Delaware hospital. Of the two VA medical centers in the State, both are located in northern New Jersey. The outpatient clinic in Newark is extemely busy. It is frequently plagued with staffing shortages and equipment breakdowns. Quite simply, it cannot handle the demand for outpatient services in the State.

By 1990, 7.2 million veterans nationwide will be over 65, doubling the total for 1980, Mr. Chairman. These veterans will all be eligible for free medical care from the VA. This proposed clinic in southern New Jersey will make it possible for us to not only meet the current unmet demand, but also to prepare for the future.

The proposed clinic would treat minor surgery, fill pharmaceutical needs and provde local diagnostic services for veterans in Ocean, Monmouth, Burlington, Mercer and Atlantic counties.

Mr. Chairman, since the completion of the MEDIPP study, the New Jersey clinic has received Level 3 approval, the highest level of approval from the VA for such a project. Level 3 approval means that the proposal is appropriate for possible inclusion in a VA budget request. I, again, request that the committee include language in the 1988 Budget for the southern New Jersey outpatient clinic.

Thank you, Mr. Chairman.

Statement of Congressman Charles E. Bennett

Subcommittee on Hospitals and Health Care

House Committee on Veteran's Affairs

March 11, 1987

Mr. Chairman, thank you for the chance to testify on the Veterans' Admininstration medical construction authorization request for fiscal year 1988. There is a serious shortage of Veterans Admininstration facilities in Florida, and Jacksonville is the most populous city in Florida without a V.A. hospital. In all fairness to the veterans of this area, a veterans' hospital should be promptly established in Jacksonville.

During the past decade, Florida has experienced a greater rate of growth in its veteran population than any other state in our nation. With this expansion , along with a growing population base, comes the need to provide medical care and services that are mandated by law for veterans.

My bill, H.R. 68, provides for a Veterans' Administration general medical and surgical hospital at Jacksonville, Florida, and seeks to achieve cooperation with the University of Florida College of Medicine in its activities in Jacksonville.

Jacksonville has one of the largest concentrations of retired and active-duty personnel of any metropolitan area in the nation. Its surrounding area has the third largest concentration of veterans in the State of Florida. This is projected to remain steady for many years to come. Yet the nearest Veterans hospital for this major concentration of veterans is more than a three hour round trip away. Gainesville and Lake City, the two nearest city with VA hospitals, do not even have a significant military or veterans presence, such as Jacksonville.

The increasing age and increasing numbers of Florida veterans will increase demand. In the future Americans are projected to live longer and demand more services and more of them are coming to Florida. As the average age of the veteran population increases and the demands on the system grow, we must locate a Veterans' Admininstration hospital in the Jacksonville area, one of the primary concerntration of Veterans. This belief is echoed by the Veterans Administration, which declares that its systematic planning efforts are designed to assure that VA facilities are located where the need is greatest. Having Veterans' Administration hospitals an hour and a half away for the state's third largest concentration of veterans is unconscionable.

Veterans health care needs in northeast Florida or Duval County now require the establishment of a Veterans' Administration hospital in Jacksonville, which has the same boundaries as Duval County. I am grateful for these hearings and I surely hope that your committee will approve the establishment of this hospital, as it is greatly needed.

TESTIMONY OF RICHARD RAY
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
VETERANS AFFAIRS COMMITTEE
HOUSE OF REPRESENTATIVES
MARCH 11, 1987

MR. CHAIRMAN, I WANT TO THANK YOU FOR THE OPPORTUNITY TO TESTIFY BEFORE THIS SUBCOMMITTEE ON THE NEED FOR A VETERANS ADMINISTRATION OUTPATIENT CLINIC IN THE COLUMBUS, GEORGIA/CHATTAHOOCHEE VALLEY AREA.

THERE ARE OVER 60,000 VETERANS RESIDING IN THE CHATTAHOOCHEE VALLEY AREA, AND THE NUMBER CONTINUES TO GROW. IN ORDER TO RECEIVE MEDICAL TREATMENT AT A V.A. FACILITY, VETERANS FROM COLUMBUS AND THE SURROUNDING COMMUNITIES PRESENTLY HAVE TO TRAVEL APPROXIMATELY 50 MILES TO TUSKEGEE, ALABAMA OR OVER 100 MILES TO DECATUR, GEORGIA TO RECEIVE MEDICAL ATTENTION. SUCH TRIPS, ESPECIALLY FOR DISABLED VETERANS, MAKE IT DIFFICULT, IF NOT IMPOSSIBLE, FOR OUR VETERAN POPULATION TO RECEIVE ADEQUATE MEDICAL CARE.

AN ADDITIONAL FACTOR IS THAT THESE FACILITIES APPEAR TO BE OVERLOADED, REQUIRING LONG WAITS FOR APPOINTMENTS AND THEN ADDITIONAL DELAYS ONCE THE VETERAN ARRIVES.

MR. CHAIRMAN, MANY PEOPLE POINT TO THE PRESENCE OF FORT BENNING IN THE CHATTAHOOCHEE VALLEY AREA, AND CITE THE MEDICAL FACILITIES AT THE BASE AS A RESOURCE FOR AREA VETERANS. WE ARE ALL AWARE THAT MILITARY HOSPITALS APPROPRIATELY GIVE FIRST PRIORITY TO MILITARY PERSONNEL AND THEIR FAMILIES. THIS MEANS THAT AVAILABLE MEDICAL SERVICES FOR RETIREES ARE LIMITED.

THE RECENT ANNOUNCEMENTS THAT D.O.D. IS NOW IN THE PROCESS OF SELECTING A CONTRACTOR FOR A PRIMUS CLINIC IN THE AREA AND THAT GEORGIA WILL BE A TEST SITE FOR THE NEW CHAMPUS REFORM INITIATIVE COMPOUND THE PROBLEM SINCE VETERANS AND OTHERS MISTAKENLY BELIEVE THAT AREA VETERANS SHOULD NO LONGER HAVE DIFFICULTY GETTING THE CARE THEY NEED.

IN POINT OF FACT, HOWEVER, THERE ARE TWO PROBLEMS WITH THIS VIEWPOINT:

FIRST, RECENT GROWTH AT FORT BENNING, SUCH AS THE ADDITION OF THE 2ND BRIGADE OF THE 10TH MOUNTAIN DIVISION, THE STATIONING OF THE 75TH RANGER REGIMENTAL HEADQUARTERS AND THE THIRD RANGER BATTALION, AND THE PERMANENT SITING OF THE SCHOOL OF THE AMERICAS (ALL WITHIN THE LAST THREE YEARS), HAVE GREATLY INCREASED THE LOAD ON BASE MEDICAL FACILITIES FROM ACTIVE DUTY PERSONNEL.

THE NEW PRIMUS CLINIC AND THE CHAMPUS REFORM INITIATIVE ARE ATTEMPTS TO RELIEVE THAT STRAIN, BUT THE FIRST PRIORITY OF BASE FACILITIES WILL REMAIN ACTIVE DUTY PERSONNEL.

SECONDLY, AS I POINTED OUT, BASE MEDICAL FACILITIES, CHAMPUS AND THE PRIMUS CLINIC ARE ALL AVAILABLE ONLY TO ACTIVE DUTY, RETIREES, AND THEIR DEPENDENTS. THE VAST MAJORITY OF VETERANS ARE NOT RETIREES, AND THEREFORE CANNOT MAKE USE OF ANY OF THESE FACILITIES.

SO, ALTHOUGH THE DEPARTMENT OF DEFENSE SHOULD BE COMMENDED FOR THE VARIOUS ACTIONS THEY ARE TAKING TO RELIEVE THE PROBLEMS OF RETIREES, THIS DOES NOT ELIMINATE THE NEED

FOR THE VETERANS ADMINISTRATION TO DO SOMETHING TO SERVICE FORT BENNING AND CHATTAHOOCHEE VALLEY AREA VETERANS.

MR. CHAIRMAN, I HAVE RECEIVED A LETTER FROM THE CHATTAHOOCHEE VALLEY VETERANS COUNCIL, OUTLINING THE EFFORTS BY 44 VETERANS ORGANIZATIONS, AUXILIARIES, AND OTHER ASSOCIATED UNITS IN THE GEORGIA/ALABAMA "VALLEY" AREA TO INFORM V.A. OF THE DESPERATE NEED IN THIS AREA FOR MEDICAL FACILITIES. I ASK THAT THIS LETTER BE INCLUDED AS A PART OF THE RECORD OF MY TESTIMONY.

EXPECTATIONS ARE THAT THE VETERANS POPULATION OF THE CHATTAHOOCHEE VALLEY AREA WILL CONTINUE TO GROW AND, AS IT DOES, THE SEVERITY OF THE SITUATION FOR VETERANS WILL ONLY INCREASE WITHOUT THE ESTABLISHMENT OF AN OUTPATIENT CLINIC.

MR. CHAIRMAN, THE EXCELLENT WORK OF THIS COMMITTEE IN LOOKING AFTER THE NEEDS OF THOSE WHO HAVE SERVED OUR COUNTRY - AND PARTICULARLY YOUR OWN PERSONAL EXEMPLARY EFFORTS - ARE WELL KNOWN BY ALL OF US WHO REPRESENT VETERANS HERE IN THE CONGRESS.

I AM GRATEFUL FOR THE OPPORTUNITY TO MAKE YOU AWARE OF THIS SERIOUS PROBLEM WHICH NOW FACES US IN THIS AREA OF GEORGIA AND ALABAMA, AND I STRONGLY URGE YOUR COMMITTEE AND THE V.A. TO TAKE SOME ACTION BEFORE THE SITUATION DETERIORATES FURTHER.

IT'S VERY DIFFICULT FOR OUR VETERANS, WHO WERE PROMISED HEALTH CARE AND MEDICAL TREATMENT, TO UNDERSTAND WHY THEY ARE GETTING WHAT THEY CONSIDER TO BE "SECOND-CLASS" TREATMENT.

THANK YOU FOR YOUR CONSIDERATION OF THIS REQUEST.

TESTIMONY OF REP JAMES J. HOWARD

HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HOSPITALS & HEALTH CARE

HEARING ON V.A. FY '88 MEDICAL CONSTRUCTION AUTHORIZATION REQUEST
MARCH 11, 1987

THANK YOU MR. CHAIRMAN, I APPRECIATE THE OPPORTUNITY TO TESTIFY BEFORE THE VETERANS' AFFAIRS SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE REGARDING THE VETERANS ADMINISTRATION FISCAL YEAR 1988 MEDICAL CONSTRUCTION AUTHORIZATION REQUEST. I AM HERE TODAY WITH MY COLLEAGUES, CONGRESSMAN JIM FLORIO AND CONGRESSMAN CHRIS SMITH, TO SPEAK ON A TOPIC OF GREAT IMPORTANCE TO ONE MILLION VETERANS LIVING IN NEW JERSEY.

IN 1984, THE V.A. CONDUCTED A STUDY WHICH DEMONSTRATED A NEED FOR AN OUTPATIENT CLINIC IN OCEAN COUNTY, NEW JERSEY. THIS NEED WAS EVIDENCED BY THE HIGH CONCENTRATION OF VETERANS RESIDING IN CENTRAL AND SOUTHERN NEW JERSEY. BASED ON THESE FINDINGS, THE V.A. DECLARED THAT AN OUTPATIENT CLINIC FOR THIS AREA WAS OF THE HIGHEST PRIORITY. TO THIS DAY, HOWEVER, NO SUCH CLINIC EXISTS.

PRESENTLY, VETERANS IN CENTRAL AND SOUTHERN NEW JERSEY MUST DRIVE A MINIMUM OF ONE AND ONE-HALF HOURS TO REACH THE NEAREST VETERANS CLINIC IN NEWARK, NEW JERSEY. STILL OTHERS ARE FORCED TO TRAVEL TO EITHER DELAWARE OR PENNSYLVANIA TO RECEIVE CARE. SINCE 1978, WHEN THE ADMINISTRATION FIRST ANNOUNCED ITS INTENTION TO BUILD A CLINIC, COUNTLESS NEW JERSEY VETERANS HAVE WAITED PATIENTLY AND SUFFERED FROM THE LACK OF SUCH A FACILITY. GIVEN THE FACTS, I AM SURE THIS COMMITTEE UNDERSTANDS THE URGENCY OF THE NEED TO DIRECT THE V.A. TO ESTABLISH THIS CLINIC IN FISCAL YEAR 1988.

I WOULD LIKE TO COMMEND THIS COMMITTEE FOR THE STEPS IT HAS ALREADY TAKEN ON THIS MATTER AND URGE THAT IT CONTINUE ITS FINE WORK. MR. CHAIRMAN, THANK YOU ONCE MORE FOR THIS OPPORTUNITY. I WISH THE COMMITTEE THE BEST IN THIS 100TH CONGRESS.

Testimony of
DAVE McCURDY, M.C.
before the
Committee on Veterans' Affairs
House of Representatives
March 11, 1987

I appreciate this opportunity to appear before the Committee to discuss the urgent need for a VA medical facility in southwest Oklahoma.

Over the past few years, several studies have been conducted by the Veterans Administration and other federal agencies concerning the need for a VA clinic in southwest Oklahoma. These studies have confirmed the great need for additional veterans medical services in this area. There are more than 70,000 veterans in southwest Oklahoma and an additional 60,000 in north Texas who would be served by this facility. These are men and women who have served their country honorably, and who currently have to drive several hours to be cared for at the Oklahoma City VA hospital.

The long journey to Oklahoma City often proves too difficult for some of our veterans. In many cases, the trip itself discourages them from seeking important medical services. I know of at least one constituent who died from a heart attack because his wife could not get him to Oklahoma City and the family could afford no other insurance.

Another serious disincentive for obtaining medical care is the long lead time in getting appointments at the Oklahoma City hospital. It is usually more than three months before a disabled veteran can get an appointment for an evaluation. The care given at the Oklahoma City hospital is excellent, but there are too many demands on its resources. A facility in Lawton would relieve overcrowding at both Oklahoma City and Muskogee.

The Veterans Administration identified the need for additional outpatient services in Southwest Oklahoma in 1983. But for the past four years it has been unwilling to request the funds to make those services available. In spite of great enthusiasm from the Lawton, Oklahoma community, where the proposed services will be centered, and from the Oklahoma congressional delegation, the VA has not advanced development of the clinic except to begin a study of whether a VA-owned facility would be more cost effective than leasing space to support a new clinic. The agency appears unwilling to request budget authority for an outpatient clinic in the area prior to the mid-1990s.

Mr. Chairman, our veterans simply cannot wait that long. We need your assistance in taking the proposed Lawton Veterans Outpatient Clinic off the agency's backburner and placing it high on the priority list. A recent report from the VA confirms the long-term trends pertaining to the aging of the veteran population. As you know, the proportion of veterans over age 65 has grown from seven percent to sixteen percent since 1970, and is expected to exceed 33 percent by 1995. Older people use more inpatient and outpatient medical services than younger ones. I realize that many areas of the country are clamoring for VA outpatient clinics. However, I also believe that Southwest Oklahoma is unique because of the high concentration of veterans who reside in the area.

Mr. Chairman, you have taken the time to visit my District and I know that you are aware of the significant veterans population. All of us in the Oklahoma Congressional delegation and veterans throughout the region are grateful for your personal interest and support.

Again, Mr. Chairman, I appreciate the opportunity to appear before this distinguished Committee and I will be glad to try to provide any additional information you may need.

Testimony by

NICK J. RAHALL, II
Member of Congress
State of West Virginia
Fourth Congressional District

on

March 11, 1987

before the

COMMITTEE ON VETERANS AFFAIRS

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

Mr. Chairman, I would like to thank you and the other members of the Subcommittee on Hospitals and Health Care here today for this opportunity to testify on the to Veterans' Administration (VA) medical construction authorization request for fiscal year 1988.

The President's fiscal year 1988 budget contains a provision which would fund a much needed expansion project at the Huntington, West Virginia Veterans Administration Medical Center (VAMC). As the representative of Huntington, it is my pleasure to testify before you today on the need for this expansion project and to urge that the funds for the project be included in FY88 authorization legislation. Please allow me to give you brief background information on the Huntington VAMC as well as more detail on the proposed clinical addition.

The Huntington VAMC, which is designated as the Clinic of Jurisdiction for the State of West Virginia, was one of the first constructed by the VA in 1932. This 180-bed university affiliated, secondary care center provides acute medical and surgical inpatient care, intermediate inpatient care and both primary and specialized outpatient services, including a Mental Hygiene Clinic Program. The medical center has an average of 75 patients in Community Nursing homes, and follows 50 veterans in personal care homes. The Medical Center's most pressing need is approval of the proposed South Addition.

For six years, the much needed clinical improvement project has been in the planning stages. The clinical improvement addition is necessary to correct gross space deficiencies in Surgery, Medicine, Radiology, Laboratory and Ambulatory Care as well as increase bed capacity to meet the projected facility needs. For example, currently patients with psychiatric conditions are transferred to Chillicothe or Salem VAMC for care. The addition includes a 30 bed Psychiatric Unit. Patients with psychiatric conditions will, therefore, be treated at the Huntington VAMC, closer to their homes, families and friends.

The Intensive Care Unit (ICU) is also inadequate. At this time, if more than ten patients need ICU care, the VAMC must transfer patients to community hospitals at VA expense. The proposed clinical addition, however, will provide ten Medical ICU beds and six Surgical ICU beds, each in a separate unit. Therefore, patients needing intensive care can be housed at the Huntington VAMC.

In addition, the present facility is not equipped for cardiac catheterization. Veterans in need of cardiac catheterization must have the procedure performed at community hospitals, or at Lexington, KY or Pittsburgh, PA VAMCs. Those patients fortunate enough to be transferred are away from their families and often times receive delayed care due to budget constraints or scheduling timeframes at the other hospitals. Our veterans should expect that catheterizations be performed on a timely basis at the Huntington VAMC.

The proposed addition will also allow the Medical Center to treat the ever increasing outpatient load. The plan includes a well equipped ambulatory surgery procedures area in the Outpatient unit. This will avoid unnecessary waiting for patients and will free the operating room facilities for inpatient procedures. Also, the plan calls for 30 intermediate beds, an alcohol dependency treatment clinic, and inhouse dialysis capacity. All of these represent critically important improvements.

I would like to stress that the facilities and equipment at the Huntington VAMC are in dire need of attention. The Medical Center must replace major equipment items during the next five years. T he normal equipment budget, however, will not cover the $4,650,000 cost of these items. Among the list of major items that are scheduled for replacement and relocation in the expansion are radiographic equipment, laboratory analyzers, cardiopulmonary testing system, electrocardiograph equipment, and operating room equipment.

The current laboratory and radiology suites are 50% under criteria as is the small, inadequate operating room (OR) suite, that has its recovery room located two floors below. The clinical addition will provide five new operating rooms with state of the art equipment and a new recovery room adjacent to the OR. In addition, space for radiology, lab, and rehabilitation medicine and nuclear medicine will be expanded to allow more efficient patient care and services.

Space for warehousing is another main concern. The majority of the Medical Center's warehouse space is located away from medical center grounds. This limits the efficiency and effectiveness of the storage and distribution function. The VA pays $34,380 per year for space rental, $6,750 for utilities, and hundreds of dollars for fuel/maintenance for the delivery truck. Since a previously approved project for an "on station" warehouse was postponed and included under the South Addition project, it is still needed for efficiency and adequate storage space.

Finally, the plan includes construction of a 500 car parking garage, the removal of asbestos from the main hospital, the addition of sprinklers, and modernization of the old air conditioning system.

The project will consist of a 173,000 square foot addition plus renovation of approximately 57,000 square feet to existing space. The addition will be constructed in a manner to directly tie-in with the southeast end of Building One and indirectly connect with Building Two via a connecting corridor. Two additional floors will be added to Building 1A and will link with Building One and the new addition. Asbestos removal, replacement of air-conditioning systems and installation of a sprinkler system is included with the renovation work. The 500 car parking garage will be constructed to the north of Building 12.

If the proposed expansion to the Huntington facility is included in authorization and appropriation legislation for fiscal year 1988, the VAMC will be able to adjust to the shifting and increasing needs of the tri-State area it services. If delayed beyond fiscal year 1988, however, many of the Medical Center's current needs will be exacerbated.

While the Medical Center is located on the western most boundary of West Virginia, it is of equal importance to neighboring Ohio and Kentucky. It serves 144,000 veterans throughout nine counties in West Virginia, eight counties in Ohio, and eleven counties in Kentucky. The population of this area is primarily rural and is slightly older than the national average. It is also important to note that this area has the highest percentage of unemployment in the nation and the rural areas do not enjoy adequate medical facilities.

The veterans residing in this tri-State area depend on the availability of quality care at the Huntington VAMC. As I am sure you will agree, it is not Congress' intention for these 144,000 veterans to travel long distances unnecessarily to obtain much needed and deserved medical care. There is a true and dire need for this expansion project and the services it will provide.

As members of the House Committee on Veterans Affairs, you have great experience in understanding and addressing the health care needs of America's veterans. I appreciate and applaud your endeavors in this vein. Therefore, I come to you, as a fellow Member of the House and on behalf of the 144,000 veterans who are served by the Huntington VAMC to request that authorization of funding for the proposed clinical addition at the Huntington VAMC be included in fiscal year 1988 VA authorization legislation. The President recognized the importance of this project and included $47.5 million in his budget, $43.4 million in the construction account and $4.1 million in the parking fund, for this purpose. The merits of this proposal are self-evident, and I am confident that this committee will authorize a comparable amount.

Again, I would like to thank Chairman Montgomery and each member of the Subcommittee on Hospitals and Health Care in attendance for the opportunity to testify before this panel today. The veterans in my district and throughout the tri-State area served by the Huntington VAMC are looking to Congress for help. These 144,000 veterans are not asking for extravagant or luxurious reform of this VA facility. They are asking that their health care needs be addressed in a timely fashion through the use of adequate space and up-to-date medical equipment. Furthermore, they are asking that VA grounds and facilities be used to the utmost to avoid unnecessary cost to the taxpayer. I join these veterans in requesting that the necessary funds be authorized to meet these needs. I am sure that the members of this Subcommittee appreciate these needs and urge that funds be authorized accordingly.

TESTIMONY OF PATRICK L. SWINDALL
TO THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
MARCH 11, 1987

Mr. Chairman, I would like to thank you for the opportunity to come before this subcommittee to express to you the need for the clinical addition to the Medical Center in Atlanta, Georgia.

As you know, Metropolitan Atlanta has experienced significant growth over the past ten years. It has achieved national stature as one of the fastest growing metropolitan areas in the country. The population in this area has expanded by almost 30 percent from 1.9 million in 1975 to 2.5 million in 1985. The veterans population in this area and throughout north Georgia has increased as well during this period. This hospital's primary service area covers 59 counties containing an estimated population of nearly 4 million people with over 400,000 veterans. The Veterans Administration estimates that by the year 2000, the veterans population will increase by 2% in contrast to a decrease in the national veterans population. In addition to the steady growth of veterans in this area, the number of veterans over 65 years of age served by this Medical Center is expected to rise by an extraordinary 133% by the year 2000.

This Medical Center opened in 1966 and since then, the number of patients, the range of services, and sophistication of medical care has increased substantially. Despite these developments, only limited improvements or expansion of facilities have taken place. Currently, the limited amount of space has caused serious problems for the hospital. Inadequate departmental layouts have led to inefficient workflow, insufficient waiting space, lack of privacy, storage, and other support elements. In many instances, departments have become fragmented. Functional relationships between many critical areas, such as surgery, intensive care units, and diagnostic services are seriously inadequate, resulting in inefficient operations. Medical and surgical intensive care units are currently separated by three floors, and both intensive care units are several floors from the operating room area. Plans contained in the design of the clinical addition will alleviate this significant problem. By VA standards, this hospital is 47% below space requirements for the various clinical services that provide care for our veteran patients. As the hospital expands its programs in areas such as open heart surgery, chemosurgery, and long term care for the increasing needs for the aging veterans, the need for additional space will grow dramatically.

There are presently 550 hospital beds, and 120 beds in the nursing home. It is estimated that by 1992, the Medical Center must increase the number of hospital beds to 675 in order to continue to provide sufficient health care. Currently, the Atlanta area is served by the smallest number of VA medical beds for any major metropolitan area.

Over the years, this facility has made significant contributions to the community. I cannot neglect to mention these contributions as a vital factor in the need for this project. This hospital is affiliated with the Emory University School of Medicine, which is one of the finest medical schools in the Southeast. There are over 20 various residency programs including rehabilitation, psychiatry, and radiology. The research facility is currently working on 30 VA funded research programs, and over 40 extra-VA funded medical research projects. In order to accomodate the high tech equipment and staff needed for these projects, additional space is needed.

The proposed project includes the construction of a five story clinical addition and alteration to the main building to accommodate the new addition. Approximately 50% of the Medical Center will be upgraded and expanded to provide adequate space. The proposed addition will help the hospital achieve the basic space requirements established by the VA.

Also included in the project is the construction of a 750-space parking deck. The 1990 parking analysis shows a need for 1,390 parking spaces. Construction of the new clinical addition will displace approximately 450 spaces. Consequently, a parking structure and realignment of the site circulation is essential to meet the projected requirements.

A significant part of this project is the removal of the remaining asbestos from over 200,000 square feet of the facility. This work is imperative because it is holding up installation of new medical equipment, such as a microscope in the ceiling for eye surgery or x-ray equipment in the walls.

It is estimated that it would cost approximately $20 million for more than 25 different projects which would be required in the next 5 years, if the clinical addition and parking deck are not built. None of these projects would have any positive impact on the space shortage and would only compound the space problems. I am sure you would agree that it is much better to solve the problem now, rather than resort to a patchwork approach to solving the problem. It is my hope that we will not have to continue to compromise medical care for these veterans. As you can tell from the figures that I have presented to you this morning, there is a desperate need that cannot be delayed any further. I strongly urge you to accept the recommendations of the national VA and approve the funding for this project. Thank you for allowing me this time to represent the thousands of veterans who are served by this hospital, and for your deepest consideration of the project.

# # #

Congress of the United States
House of Representatives
Washington, D.C. 20515

JOHN BRYANT
5th District, Texas

COMMITTEE ON
ENERGY AND COMMERCE

COMMITTEE ON
THE JUDICIARY

COMMITTEE ON
VETERANS' AFFAIRS

February 11, 1987

General Thomas K. Turnage
Administrator of Veterans Affairs
Veterans Administration
Washington, D.C. 20420

Dear General Turnage:

As a Congressman representing Dallas County, I am eager to understand the Veterans Administration's rationale for once again omitting the funding for the critical Project #549-031, which would make additions and renovations to the Dallas Veterans Administration's Medical Center (VAMC).

In expressing my concern for this construction project last year, I was informed that the funding for the completion of the working drawings had to be postponed until FY '88 because of the significant cuts made by the Office of Management and Budget in the Veterans Administration's construction budget. I was assured that the funding for the completion of the working drawings was on the VA list of ten high priority construction items under the five-year plan. I was made relatively certain that such funding would be included in the FY '88 Project Development Plan. However, the Dallas veterans have once again been disappointed.

The enclosed FY 1988 Project Development Plan seems to reveal that the Dallas VAMC was "skipped over" while VAMC's of comparable age received funding for renovations and additions. As I am sure you are aware, the "newest" patient building of the Dallas VAMC was built in 1952. The need for the Clinical Addition has been critical for a long time.

The "Construction Concept" for Project #549-031 dictates the addition of approximately 300,000 gross square feet of floor space and the total renovation of the main medical and surgical inpatient facility, Building #2. A 30-bed Long Term Spinal Cord Injury (SCI) Unit and a 30-bed Acute-Sustaining SCI Unit are also included in the construction plan.

The Dallas VAMC has a 28-county primary service area which includes 473,000 veterans, and this number has increased each of the last 10 years. In 1986, the VAMC's workload increased by 80,000 visits over that of 1985. The Cardiac Intensive Care Unit (ICU) and the Surgical ICU, each of which would be expanded by Project #549-031, are now stretched to the limit. According to Mr. Wayne Hawkins, the Dallas Medical Center Director who testified at the House Veterans' Affairs Committee hearing of February 4, 1987, even the performance of open-heart surgery was recently postponed due to lack of beds. The need for more beds in each of these ICUs will become increasingly necessary due to the heavier demand on cardiac surgery that accompanies an aging veterans' population. At present, elective surgeries, for example in the areas of opthomology and urology, are also backed up due to the lack of operating room facilities.

The Veterans Administration has already spent approximately $3.5 million to develop both the concept and the preliminary plans for this project, which began in August of 1983. A delay in the funding for the completion of the working drawings will either increase the total construction cost, which I realize is estimated to be $140 million, or require the size of the project to be decreased. I do not want either of these results. In addition, please consider that, if a further delay in the completion of the working drawings is sustained, the actual construction could not be completed prior to FY 94. This is a long time to require those now in need of this facility to wait--especially since they must now travel 6 hours to Houston, Texas, where the nearest SCI Unit is located, to receive treatment.

In the interest of cost-efficiency as well as proper attention to the needs of the thousands of my constituents who faithfully served our nation in the armed forces, I urge you to provide for the expedited completion of Project #549-031 for the Dallas veterans.

I look forward to a prompt reply. Thank you for your consideration.

Sincerely,

John Bryant

JOHN BRYANT
Member of Congress

Enclosure

jb/sol

STATEMTENT OF THE HONORABLE DAN GLICKMAN BEFORE THE VETERAN'S AFFAIRS SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

Chairman Montgomery and Members of the Subcommittee, I appreciate your giving me the time to address an issue of great interest to me and to the veterans in my area. Specifically, I am here to express my strong support for the proposed colocation of the Wichita regional Veterans Administration with the medical center. The Administration's budget request for 1988 provides funding for this colocation project. I am supportive of this request because it will not only provide substantial long term cost savings to the federal government, but it is also consistent with PL 99-576 which required the VA Administrator to submit to the Veterans Affairs Committee by this March 1 a plan for colocation of at least 7 facilities.

By way of background, the Wichita Medical and Regional Office Center is a combined office for administrative purposes in delivering medical and benefit entitlements to veterans and their families. Nearly 300,000 veterans are served by the combined office. Although combined for administrative purposes, the activities are separated into two physical locations. These offices are approximately three miles apart, resulting in many functions being duplicated and all too many delays in providing services. Additionally, because the offices are separate, veterans are frequently forced to travel back and forth between the regional office and the medical grounds to obtain needed information and assistance. Often veterans mistakenly report to the regional office for scheduled medical appointments. Colocation of the regional office on the medical center grounds would eliminate many of these problems and improve the delivery of benefits.

In addition to alleviating these logistical difficulties, colocation would provide a long term cost savings to the VA. Presently the regional office is rented at an annual cost of $388,152. Colocation would obviously eliminate this cost. Other cost savings would also occur as a result of the colocation. For example, the VA pays $4,800 for guards at the regional office. Relocation of the regional office to the medical center would eliminate this expense as security service is already available on the medical grounds. Another area where substanial savings would occur is through the elimination of the shuttle service between the two facilities. Currently the VA operates, on a regular basis, a shuttle service between the two offices. Colocation would eliminate the need for one GSA vehicle and one vehicle driver required to provide this shuttle service. The annual cost savings from this would be $25,000. Colocation would also mean that certain services such as teletype clerk and clerk typist could be combined.

As mentioned earlier, there is another important reason for supporting the colocation. That is that in PL 99-576 which originated in this committee and was signed in October 1986, Congress specifically directed the VA Administrator to submit to the Veteran's Affairs Committee by March 1 of this year a plan for colocation for at least 7 facilities. The colocation of the

Wichita offices is part of that directive.

In closing, I want to emphasize that the proposed project will correct the operational difficulties I have spoken of, eliminate the need to rent in the future, and enhance convenience for Wichita area veterans which you realize, as I do, can be vitally important.

I urge you to give this proposal your valued support.

STATEMENT

BY

G. E. NEUMANN

DIRECTOR, OFFICE OF FACILITIES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ON

MARCH 11, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM PLEASED TO APPEAR BEFORE YOU THIS MORNING TO PRESENT TESTIMONY CONCERNING THE VA'S CONSTRUCTION REQUEST CONTAINED IN THE PRESIDENT'S BUDGET FOR FY 1988. THE VA HEALTH CARE SYSTEM IS MADE UP OF 172 MEDICAL CENTERS, 120 NURSING HOME CARE UNITS, 16 DOMICILIARIES AND 53 INDEPENDENT AND SATELLITE OUTPATIENT CLINICS AND THIS SYSTEM STANDS OUT AS A LEADER IN THE PROVISION OF QUALITY MEDICAL CARE. THIS SYSTEM OPERATES IN OVER 5,000 SEPARATE BUILDINGS, WITH OVER 100

MILLION SQUARE FEET OF SPACE. AS YOU KNOW, WE HAVE A TREMENDOUS CAPITAL INVESTMENT REPRESENTED BY THESE BUILDINGS, WHICH ARE AGING. THE VA MUST MAINTAIN A PHYSICAL PLANT CAPABLE OF DELIVERING STATE OF THE ART MEDICAL CARE; ONE WHICH CAN KEEP PACE WITH MODERN MEDICAL ADVANCES; AND RESPOND TO THE CHANGING NEEDS OF THE VETERAN POPULATION. OUR CONSTRUCTION PROGRAM REPRESENTS A COMMITMENT TO A CAPITAL INVESTMENT PROGRAM WHICH IS DEDICATED TO MEETING THE FACILITY NEEDS OF A MODERN, COMPREHENSIVE HEALTH CARE DELIVERY SYSTEM TO PROVIDE FOR OUR NATION'S VETERANS.

IN KEEPING WITH THAT COMMITMENT, THE VA'S OBLIGATIONS IN ACTUAL DOLLARS HAS BEEN MORE OVER THE PAST FIVE YEARS FOR ITS CONSTRUCTION PROGRAM THAN IN ANY PREVIOUS FIVE YEAR PERIOD IN THE VA'S HISTORY. IN THE PERIOD FROM FISCAL YEAR 1982 THROUGH FISCAL YEAR 1986, THE VA OBLIGATED OVER $2.6 BILLION. THIS IS AN INCREASE OF ALMOST $1.0 BILLION OVER OBLIGATIONS IN THE PREVIOUS FIVE YEAR PERIOD. WE ARE MAINTAINING OUR COMMITMENT WITH THE 1988 CONSTRUCTION REQUEST OF $525.7 MILLION.

SPECIFICALLY, THE FY 1988 BUDGET REQUESTS A PROGRAM LEVEL OF $525.694 MILLION. THIS AMOUNT INCLUDES AN APPROPRIATION REQUEST FOR MAJOR PROJECTS OF $400.556 MILLION, A MINOR PROGRAM OF $121.038 MILLION AND A PARKING GARAGE REVOLVING FUND OF $4.1 MILLION. WE ARE REQUESTING APPROVAL FOR FUNDING 15 MAJOR PROJECTS, $18.5 MILLION FOR THE ADVANCE PLANNING FUND, $25.0 MILLION FOR ASBESTOS ABATEMENT, AND $14.2 MILLION FOR THE DESIGN FUND. THE

REQUEST INCLUDES FUNDING FOR CONSTRUCTION OF MAJOR REPLACEMENT FACILITIES AT DAYTON, OHIO, AND NORTH CHICAGO, ILLINOIS. THE PROJECT AT DAYTON WILL PROVIDE FOR A NEW REPLACEMENT 476 BED HOSPITAL, WHILE THE NORTH CHICAGO PROJECT PROVIDES FOR MAJOR RENOVATIONS, A NEW CLINICAL ADDITION, AS WELL AS AN INCREASE IN NORTH CHICAGO'S NURSING HOME BED CAPACITY FROM 190 TO 360 BEDS. WE ALSO ARE REQUESTING FUNDING, IN FISCAL YEAR 1988, FOR THE DESIGN OF A CLINICAL ADDITION/PARKING GARAGE PROJECT AT ATLANTA, GEORGIA· DESIGN AND SITE PREPARATION FOR A NEW MEDICAL CENTER IN PALM BEACH, FLORIDA; AND FUNDS FOR PHASE I CONSTRUCTION OF A REPLACEMENT MEDICAL CENTER AT PITTSBURGH (ASPINWALL), PENNSYLVANIA.

IN ADDITION, THIS BUDGET REQUEST INCLUDES TWO CLINICAL IMPROVEMENT PROJECTS, THREE FIRE AND SAFETY IMPROVEMENTS PROJECTS, ONE DOMICILIARY PROJECT, ONE OUTPATIENT IMPROVEMENTS PROJECT, ONE NATIONAL CEMETERY PROJECT AND ONE REGIONAL OFFICE PROJECT, THE RELOCATION OF THE WICHITA REGIONAL OFFICE ONTO MEDICAL CENTER GROUNDS. THIS PROJECT HAS BEEN SUBJECT TO EXTENSIVE COST BENEFIT ANALYSIS AND IS IN THE BEST ECONOMIC INTEREST OF THE GOVERNMENT. OUR MINOR CONSTRUCTION PROGRAM REQUEST OF $121.038 MILLION INCLUDES $63 MILLION FOR THE CONSTRUCTION OF MEDICAL RELATED PROGRAMS. INCLUDED IN THIS REQUEST IS $4.5 MILLION FOR THE CONVERSION OF 189 EXISTING HOSPITAL BEDS TO NURSING HOME BEDS. THE FY 1988 MINOR CONSTRUCTION REQUEST ALSO INCLUDES $3.06 MILLION FOR THE REGIONAL OFFICE PROGRAM; $6.02 MILLION FOR THE NATIONAL CEMETERY

PROGRAM; $6.22 MILLION FOR STAFF OFFICES AND $42.738 MILLION FOR GENERAL ADMINISTRATION. THE REQUESTED INCREASE IN GENERAL ADMINISTRATION IS PRIMARILY THE RESULT OF INCREASED PAY COSTS DUE TO THE NEW FEDERAL EMPLOYEE RETIREMENT SYSTEM AND THE RECENT PAY RAISE.

THE FY 1988 MEDICAL FACILITY CONSTRUCTION BUDGET REQUEST IS A PRODUCT OF THE PLANNING AND DEVELOPMENT EFFORTS OF THE DEPARTMENT OF MEDICINE AND SURGERY AND THE OFFICE OF FACILITIES. THE MEDICAL DISTRICT INITIATED PROGRAM PLANNING PROCESS (MEDIPP) SERVES AS THE INITIAL PROGRAMMATIC BASIS OF CONSTRUCTION PLANNING IN THE VA. THROUGH THIS PROCESS, THE VA'S 27 MEDICAL DISTRICTS, USING STATE OF THE ART PLANNING TOOLS AND GUIDANCE PROVIDED FROM THE CHIEF MEDICAL DIRECTOR, DEVELOP PLANS TO PROVIDE SERVICES TO THOSE VETERANS WHO USE THE VA HEALTH CARE SYSTEM. THESE PLANS, WHICH IDENTIFY MEDICAL PROGRAMS AND LEVELS OF SERVICE, ARE REVIEWED, MODIFIED (IF NECESSARY) AND APPROVED IN VA CENTRAL OFFICE. THIS SERVES AS THE BASIS FOR THE DEVELOPMENT BY EACH MEDICAL CENTER OF A FIVE YEAR FACILITY PLAN -- A PLAN WHICH IDENTIFIES FACILITY REQUIREMENTS AND PROJECTS TO CORRECT DEFICIENCIES AND TO PROVIDE THE NECESSARY PHYSICAL PLANT TO MEET PROGRAMMATIC OBJECTIVES.

WE HAVE RECENTLY BEGUN THE IMPLEMENTATION OF A MAJOR INITIATIVE WHICH WE BELIEVE WILL SIGNIFICANTLY IMPROVE OUR FACILITY PLANNING PROCESS. THIS INITIATIVE, RECOMMENDED BY THE BOOZ, ALLEN AND

HAMILTON/RIKL REPORT, IS THE ESTABLISHMENT OF A FACILITY DEVELOPMENT PLAN (FDP) FOR EACH VA MEDICAL CENTER. AN FDP IS A WRITTEN, COMPREHENSIVE PLAN FOR THE PHYSICAL DEVELOPMENT OF EACH MEDICAL CENTER OVER A SPECIFIC PLANNING HORIZON. THE VA HAS BEGUN BY TESTING THE FDP APPLICATION AT FOUR MEDICAL CENTERS: MARION, ILLINOIS; MARION, INDIANA; LONG BEACH, CALIFORNIA; AND NORTHPORT, NEW YORK. THESE PILOT TESTS BEGAN IN JANUARY 1987, AND WILL SERVE TO GUIDE THE VA IN THE WIDER APPLICATION OF THE FDP CONCEPT TO ALL MEDICAL CENTERS.

CURRENT PLANS ENVISION BEGINNING FDP DEVELOPMENT AT 40 VA MEDICAL CENTERS IN THE FOURTH QUARTER OF FY 1987, AND FUNDS HAVE BEEN PROVIDED IN THE FISCAL YEAR 1987 APPROPRIATION FOR THIS PURPOSE. THE FY 1988 BUDGET CONTAINS, AS PART OF THE ADVANCE PLANNING FUND REQUEST, AN ADDITIONAL $10 MILLION TO BEGIN 40 MORE FDPS. IN FY 1989 IT IS EXPECTED THAT THE FDPS FOR ALL REMAINING VA MEDICAL CENTERS WILL BEGIN. THE TOTAL COST FOR THE FDPS REQUIRED SYSTEMWIDE IS ESTIMATED TO BE BETWEEN $30 AND $40 MILLION. THE FACILITY DEVELOPMENT PLANS WILL SERVE AS THE BASIS FOR THE PREPARATION OF A FIVE YEAR PLAN FOR EACH MEDICAL CENTER AND IN THE AGGREGATE WILL GUIDE NATIONAL RESOURCE DISTRIBUTION PLANNING IN THE CONSTRUCTION ARENA. THE DATA PRODUCED THROUGH THE FDP PROCESS WILL BE VALUABLE TO THE AGENCY IN ASSESSING OVERALL CAPITAL REQUIREMENTS AND IN ESTABLISHING PRIORITIES. WE WOULD BE PLEASED TO KEEP THE COMMITTEE INFORMED OF OUR PROGRESS IN THIS AREA.

I WOULD ALSO LIKE TO REPORT ON THE STATUS OF THE REALIGNMENT OF OUR CONSTRUCTION ACTIVITIES AND THE FORMATION OF THE OFFICE OF FACILITIES (O/F). AS YOUR KNOW, UNDER THE REALIGNMENT, THE OFFICE OF FACILITIES IS FULLY RESPONSIBLE FOR ALL ASPECTS OF AN INTEGRATED CAPITAL FACILITIES PROGRAM AGENCY-WIDE. WITH POLICY AND GUIDANCE FOR ENGINEERING OFFICERS IN THE FIELD, COORDINATED WITH ALL OTHER FACILITY MATTERS IN THE OFFICE OF FACILITIES, THE MAINTENANCE AND REPAIR PROGRAM WILL NOW BE FULLY COORDINATED WITH ALL OTHER CAPITAL IMPROVEMENTS PROJECTS AT THE MEDICAL CENTERS, DISTRICTS, AND ON A NATIONAL LEVEL. THIS WILL GREATLY ENHANCE THE OFFICE OF FACILITIES' ABILITY TO MANAGE AND OVERSEE THE ENTIRE PROGRAM AND WOULD CENTRALIZE IN ONE SPOT THE RESPONSIBILITY FOR PERFORMANCE.

SINCE OCTOBER 1, 1986, SIGNIFICANT PROGRESS HAS BEEN MADE IN ESTABLISHING THE OFFICE OF FACILITIES. MAJOR ORGANIZATIONAL CHANGES HAVE BEEN PUT INTO EFFECT WHICH WILL AID IN ACHIEVING OUR ORGANIZATION'S GOALS. THESE CHANGES INCLUDE STREAMLINING THE OVERALL ORGANIZATION AND REDUCING THE NUMBER OF ELEMENTS REPORTING DIRECTLY TO THE HEAD OF THE OFFICE OF FACILITIES. SEVERAL OTHER MANAGEMENT IMPROVEMENTS HAVE BEEN INSTITUTED. ONE IS THE USE OF A PROJECT MANAGEMENT CONCEPT WHEREBY ONE INDIVIDUAL IS RESPONSIBLE AND ACCOUNTABLE FOR EACH PROJECT. ANOTHER IS TO ASSIGN COORDINATION OF ALL CONSTRUCTION PLANNING ACTIVITIES FOR EACH MEDICAL

CENTER TO A SPECIFIC FACILITY PLANNER. THE NAMES OF THE INDIVIDUALS FOR BOTH INITIATIVES HAVE BEEN PROVIDED TO THE MEDICAL CENTERS. ONE LAST INITIATIVE IS THE ADOPTION OF A MATRIX FORM OF OPERATION. THIS WILL PROVIDE PROJECT MANAGERS AND FACILITY PLANNERS A RESOURCE OF PROFESSIONAL, TECHNICAL, AND ADMINISTRATIVE EXPERTISE TO DRAW UPON AS NEEDED.

THE OFFICE OF FACILITIES HAS BEEN WORKING CLOSELY WITH DEPARTMENTS AND STAFF OFFICES TO INSURE THAT FULL COMMUNICATIONS AND SUPPORT MECHANISMS HAVE BEEN AND ARE CONTINUING TO BE ESTABLISHED SO THAT A FULL RANGE OF INFORMATION IS DISSEMINATED. AN EXAMPLE IS ATTENDANCE AND ARRANGEMENT OF RECURRING MEETINGS WITH PROGRAM OFFICIALS. THE OFFICE OF FACILITIES' INAUGURAL INFORMATION LETTER WAS DISTRIBUTED TO ALL VA ELEMENTS, INCLUDING THE MEDICAL CENTERS, AND THE FIRST JOINT CHIEF ENGINEERS/RESIDENT ENGINEERS CONFERENCES HAVE JUST BEEN COMPLETED. THESE CONFERENCES ALSO SERVED AS THE FORUM TO SELECT A CHIEF ENGINEER ADVISORY BOARD. THIS BOARD WILL WORK CLOSELY WITH CENTRAL OFFICE AND CONSIDER TOPICS AND PROVIDE ADVISORY RECOMMENDATIONS TO THE DIRECTOR OF THE OFFICE OF FACILITIES AND DM&S' DIRECTOR FOR OPERATIONS.

WE EXPECT SIGNIFICANT IMPROVEMENTS TO RESULT FROM OUR RECENT REALIGNMENT OF OUR CAPITAL FACILITIES PROGRAMS. SOME IMPROVEMENTS HAVE BEEN EFFECTED IMMEDIATELY SUCH AS THE NEW STREAMLINED ORGANIZATION, THE INTEGRATION OF ALL CAPTIAL FACILITIES PROGRAMS IN ONE

STAFF OFFICE, THE REINSTITUTION OF POST OCCUPANCY EVALUATIONS, THE ADOPTION OF THE PROJECT MANAGER CONCEPT AND ROUTINE ATTENDANCE BY OFFICE OF FACILITIES LEADERSHIP AT DM&S STAFF MEETINGS. HOWEVER, OTHER IMPROVEMENTS WILL TAKE LONGER, SUCH AS THE IMPLEMENTATION OF FACILITY DEVELOPMENT PLANS FOR ALL VA MEDICAL CENTERS, IMPROVEMENTS IN OUR SPACE PLANNING CRITERIA AND THE ESTABLISHMENT OF A NATIONAL DATA BASE OF INFORMATION ON FACILITY CHARACTERISTICS AND REQUIREMENTS. TAKEN TOGETHER, HOWEVER, WE ANTICIPATE THAT THE MAJOR CHANGES WE HAVE MADE IN OUR ORGANIZATION AND PROCEDURES IN THE CAPITAL FACILITIES PROGRAM AREA WILL STRENGTHEN THE PROGRAM AND MAKE IT MORE RESPONSIVE TO THE REQUIREMENTS OF THE OPERATING DEPARTMENTS.

ALTHOUGH IN EXISTENCE FOR A VERY SHORT TIME, THE OFFICE OF FACILITIES AND THE REST OF THE VA HAVE WORKED TOGETHER TO MAKE THE TRANSITION SMOOTH AND EFFECTIVE.

MR. CHAIRMAN, I WOULD LIKE TO THANK YOU FOR THE OPPORTUNITY TO APPEAR HERE TODAY, AND MY COLLEGUES AND I WOULD BE PLEASED TO ANSWER QUESTIONS THAT YOU OR THE OTHER MEMBERS MAY HAVE.

DULUTH-SUPERIOR SOC PSA
(SATELLITE OUTPATIENT CLINIC POPULATION SERVICE AREA)

The following 1995 veteran population data was used to obtain the PSA for the Duluth-Superior SOC:

STATE	COUNTY	1995 VET POP
Minnesota	Aitkin	1520
"	Carlton	3750
"	Cook	520
"	Itasca	5450
"	Koochiching	2140
"	Lake	2100
"	Lake of the Woods	470
"	Pine	2410
"	St. Louis	27870
	SUBTOTAL	46230
Wisconsin	Bayfield	1520
"	Burnett	1630
"	Douglas	5690
"	Washburn	1560
	SUBTOTAL	10400
	PSA TOTAL	56630

BID DEVIATIONS

The following chart represents the average percent deviation between the original estimate and the actual bid for projects bid in each of the last six years.

FY	# OF PROJECTS	CONSTRUCTION COST IN BUDGET	DEVIATION FROM BUDGET
1981	46	$215,991,900	-18.17%
1982	17	$182,759,000	-22.25%
1983	38	$607,299,478	-37.69%
1984	17	$229,592,000	-30.97%
1985	23	$195,000,000	-16.73%
1986	29	$448,436,000	+ 0.53%

AVERAGE DEVIATION = -21.06% for the last six years

NOTES:

- o Moved in recent years from double digit inflation to below 4% - estimates for some of those projects made three years ago.
- o Accurate estimating a problem and a trend being experienced by both federal and private construction.
- o New procedures require that architect-engineer be selected and later evaluated (in part) on their estimates.
- o Revising our own in-house computer forecasting.

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS

THANK YOU, MR. CHAIRMAN.

I, TOO, WANT TO COMMEND OUR COLLEAGUES WHO TESTIFIED BEFORE US TODAY ON BEHALF OF NEEDED VA CONSTRUCTION PROJECTS IN THEIR STATES. IT IS A MOST UNUSUAL AND MOST IMPRESSIVE TURNOUT WHEN SO MANY MEMBERS OF CONGRESS TAKE TIME OUT OF THEIR SCHEDULES TO TESTIFY BEFORE A SUBCOMMITTEE, AND WE HAVE WRITTEN TESTIMONY FROM SEVERAL OTHER MEMBERS.

IT IS AN INDICATION OF THE UNMET NEEDS THAT EXIST AMONG THE NATION'S VETERAN POPULATION AND THE IMPORTANCE THE CONGRESS PLACES ON CARING FOR OUR VETERANS.

HOWEVER, I THINK IT IS ALSO, SADLY, AN INDICATION OF A VERY SERIOUS PROBLEM IN THE VA CONSTRUCTION PROGRAM. AND THAT IS THE LACK OF A PRECISE AND UNDERSTANDABLE METHOD OF PRIORITIZING CONSTRUCTION NEEDS.

THERE CONTINUES TO BE CONFUSION AND FRUSTRATION ON THE PART OF VETERANS AND THEIR REPRESENTATIVES IN CONGRESS ABOUT HOW PROJECTS ARE PRIORITIZED AND SELECTED FOR FUNDING. I KNOW I AM AMONG THE CONFUSED AND FRUSTRATED.

SO I HOPE THAT WE CAN GET SOME ANSWERS TODAY--CLEAR AND CONCISE ANSWERS--TO SOME OF THE QUESTIONS MANY OF US HAVE ABOUT THE PRIORITIZATION OF VA CONSTRUCTION PROJECTS, AND I LOOK FORWARD TO THE REMAINDER OF THE TESTIMONY.

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

on

VA MEDICAL CONSTRUCTION

March 11, 1987

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
MARCH 11, 1987

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates this opportunity to provide specific comment on the Veterans Administration medical construction authorization request for fiscal year 1988, and on several related issues that are of importance to this organization.

The Administration's budget proposal recommends a nominal increase in the VA's construction programs of close to $37 million, up to $525.7 million.

The VA construction program is now funded by three appropriations: Construction, Major Projects; Construction, Minor Projects; and the Parking Garage Revolving Fund.

The Construction, Major Projects appropriation provides for constructing, altering extending and improving any VA facility, including planning, architectural and engineering services, and site acquisition, where the estimated cost of a project is $2 million or more, or where funds for a project were made available in a previous major project appropriation.

The Construction, Minor Projects appropriation provides for constructing, altering, extending and improving any VA facility, including the same services as with major construction, where the estimated cost of a project is less than $2 million, and for personnel and other expenses of the Office of Facilities.

The Parking Garage Revolving Fund provides for constructing, altering, or acquiring by purchase, lease, donation, exchange, or condemnation (including site acquisition), a parking facility or facilities for the accommodation of vehicles of employees of medical centers, visitors and other individuals having business at such facilities, or vehicles used to transport patients to and from the facilities.

According to the budget document, no money will be reprogrammed from the major working reserve in FY 1988.

Mr. Chairman, The American Legion is pleased that there is a proposed increase in medical construction. We feel that it reflects a recognition of the need for renovation and replacement projects within the system. However, there are specific concerns which we shall address in a moment.

An important point, which The American Legion has espoused for several years, must be reiterated at this juncture. There is a distinct need for adequate funding for medical construction in the Veterans Administration because the capital plant of the VA health care system is deteriorating. The reasons for this deterioration are manifold; one of them being serious underfunding of this program for several years until recently. This means VA is playing catch-up with its capital plant renovation and replacement program. The facilities have aged more while little was being done, and costs have escalated. It has been a losing proposition all around. Finally, the Government has been trying to make up for lost time, and it is costing a lot of money, but it is still a good investment. As we have said many times, the capital plant of the VA system is a multi-billion dollar investment by the Federal Government, and it must not be allowed to deteriorate.

Among the major medical construction projects for which funding has been requested in FY 1988 are a bed replacement and modernization at the Dayton, OH VA medical center; environmental improvements and patient and nursing home care buildings at the North Chicago, IL VA medical center; design of a new medical center in Palm Beach, FL; design of a clinical addition at the Atlanta, GA VA medical center; outpatient and ward renovations at the Montgomery, AL VA medical center; a replacement domiciliary in Prescott, AZ; a clincial improvement addition at the Huntington, WV VA medical center; and a clinical addition at the Jackson, MS VA medical center.

As for the replacement and renovation projects scheduled for FY 1988, based on the reports of our Field Representatives who make site visits to approximately 65 facilities per year, we can assure this Subcommittee that all of the work scheduled is needed, and some of it is long overdue.

It is distressing to see that only two replacement hospitals are included in the FY 1988 projection. As we have stated in the past, the Office of Management and Budget is only fooling itself by delaying the funding for badly needed projects. Such a practice is false economy and will end up costing more in the long run, rather than saving the Government money, because the longer the projects are delayed the more it will cost to build them.

Therefore, The American Legion was certainly pleased to see that the Veterans Affairs Committee recommended to the Budget Committee the addition of $15 million to the budget for the clinical addition, renovation to building 2, and Spinal Cord Injury Center at the Dallas VAMC. The extreme need for these very same projects was expressed in the report issued following the last site visit by an American Legion Field Representative to the Dallas facility, March 26-30, 1984. In the conclusion of the report, The American Legion presented a series of recommendations to VA Central Office for the purpose of addressing and correcting problems observed by the Field Rep during the course of the survey. Recommendation No. 1 cites "Approval and funding for the construction of the Clinical Addition, Renovation Building 2, and SCI Center project as planned." We certainly support the Committee's recommendation.

It concerns The American Legion that there are no nursing home care units included in the projection for FY 1988. The only funds requested for nursing care are $4.5 million under minor construction for the conversion of hospital beds to nursing care beds, and for renovation of NHC wards to meet VA criteria standards.

During the FY 1987 budget process, The American Legion expressed its extreme concern about the Administration's "plan for the future" that dictated no new independent nursing home care unit construction, and greater reliance on State veteran homes and community nursing homes. While we have no quarrel with using community nursing homes where appropriate, and we certainly support the State veteran home program, we must again express our concerns over this issue. There are some veterans who because of their levels of disability, must be cared for in VA nursing home care units.

The American Legion commends the Committee for expressing its concerns on this issue through the recommendation of two positive plans of action to the Budget Committee. Those are 1) the urging of the VA to end its policy of a static number of VA owned nursing homes with greater reliance on community nursing home beds; and 2) the recommendations to restore the 240 bed nursing home care unit to the planned VA medical center in Palm Beach, Florida which was eliminated in the Administration's proposed budget; and add 120 bed nursing home care units at the VA medical centers in Mountain Home, Tennessee and Tampa, Florida, and a 60 bed unit at VAMC Wilkes Barre, Pennsylvania.

Although not directly related to construction, an issue that is of extreme importance and somewhat analogous to the subject of today's hearing are the per diem payments to State veterans homes. We were again pleased, in reviewing the full Committee's recommendations to the Budget Committee to see a call for an increase in the per diem rates. As set forth in our statement presented to the Committee on February 4, on the full FY 1988 VA budget, The American Legion is mandated to support an annual review and revision of the rates of reimbursement by the VA for the care provided veterans in State veterans homes.

The last increases in per diem rates were set forth in PL 98-160, effective April 1, 1984. We are aware that 38, U.S.C. 641(c) currently requires the Administrator to submit a report every three years to the Committees on Veterans Affairs on the adequacy of the per diem rates payable to each State for domiciliary, nursing home and hospital care for each veteran receiving such care in a State home. The first report was to have been submitted not later than June 30, 1986. The American Legion believes that the fair sharing of the cost of providing extended care for elderly and disabled veterans will encourage States to meet the needs of the aging veteran population, and we urge that the per diem rates be reviewed, keeping in mind that they have not been increased for three years.

Also included in the construction proposal is a request for $5.4 million to relocate the Wichita, KS regional office to the VA medical center grounds. The Veterans Administration is reviewing the colocation of various regional offices onto the site of the medical center nearest that facility. Future projects will be proposed wherever they are demonstrated to be cost-effective. The American Legion is supportive of the merging of regional office and medical center activities when it is advantageous to the veteran population that is served by the facilities.

In concluding our remarks on medical construction, it must be stated that in the opinion of The American Legion, allowing the capital plant of the VA medical care system to deteriorate makes no sense at all and, in fact, contradicts the Administration's position on national defense when one considers that VA medical centers constitute the principal contingency resource to treat returning casualties during a war or national emergency.

Mr. Chairman, we would now like to take this opportunity to express the concerns of The American Legion on two specific problems within the VA medical care system. These concern the satellite outpatient clinic at New Bedford, Mass., and VAMC Walla Walla, Washington.

In the case of the New Bedford clinic, the Department of Medicine and Surgery has proposed to close the clinic and refer all patients on its rolls to VAMC Providence, RI The plan to close the clinic has been under study for a considerable period of time, and most recently has been dealt with through the MEDIPP process. Also, the VA Inspector General has completed an audit of the clinic and recommended its consolidation with Providence.

Earlier proposals to close the clinic drew opposition from local veterans organizations, including The American Legion, and closure was postponed in each instance, with Congressional interest also being displayed.

The principal arguments for closing derive from the low case load and the proposition that better and more comprehensive care can be provided with the more complete facilities and staff available at Providence. Counter-arguments from the veteran constituency in the New Bedford area range from the claim that travel to Providence or to other VAMCs would place a travel burden on the veteran clientele; to the claim that with improved equipment (i.e., radiology, laboratory) and staffing, the case load would increase to a cost-effective level.

In February, VA suddenly announced the closing of the New Bedford Clinic effective Feb. 27, 1987. This caused a vehement reaction from the veterans in Southeastern Mass., and the adoption of a resolution by the New Bedford Town Council, all opposing the arbitrary and sudden decision by VA. VACO then announced that in response to formal American Legion protest, the closing of the clinic had been postponed for 90 days.

At its 1986 National Convention, The American Legion adopted Resolution No. 190 (MA), placing this organization in support of the continuation of the New Bedford Clinic. Copy of Res. No. 190 is attached to this statement.

Mr. Chairman, and Members of the Subcommittee, The American Legion is constrained to heed the strongly felt convictions of the veterans of South eastern Mass., who are the beneficiaries of the availability of the New Bedford Clinic. There is a substantial number of these veterans, and they truly believe that a properly equipped and staffed clinic would serve an enlarged clientele and would constitute a genuine service to veterans who without the clinic would experience considerable inconvenience, even hardship, affecting jobs and personal circumstances, and resulting in veterans who need and are entitled to care from VA, not being able to receive it. The Legion believes that such deprivation is not consonant with the mission of the VA to serve sick and disabled veterans. Integrally implied in that mission is the responsibility to provide care within reach of the veteran population to be served.

It is our recommendation that the Committee, through its Subcommittee on Hospitals and Health Care take a careful and close look at the New Bedford situation, including a visitation by Committee and staff, that should include contact with some veterans in the area and then, in association with the VA, form a conclusion that is fair and equitable to the veterans in Southeastern Mass., and cost-effective for the Government.

The second specific problem we would like to call to the attention of the Subcommittee involves VAMC Walla, Walla, Washington. It is the announced intention of VA to discontinue the inpatient capability of the VAMC by the end of Fiscal Year 1987, and to maintain outpatient services for the veterans in the primary service area of the VAMC. This area covers southeastern Washington as well as counties in Oregon and

Idaho. As a matter of fact we have already had a letter of concern in this matter from the Governor of Oregon.

This decision also is based on the MEDIPP process. The stated reason by DM&S is that the inpatient case load at Walla Walla does not justify the cost for staffing, and that equally effective service can be provided through outpatient clinics and referral of veterans as necessary to Spokane and to Seattle and Portland, both of which have newly modernized tertiary level hospitals.

The reaction of the Washington State American Legion is that this action by VA is going to cause genuine hardship to many veterans . Travel in the winter time is not that easy in that part of the country; and there is inevitably the justifiable protest from seriously ill veterans, including all generations, but mostly older WW II veterans, who do not want to be separated from their families when they face major surgery or prolonged hospitalization for chronic illnesses.

Here again, we confront the matter of cost-effectiveness as against the convenience of the veterans and their families. We believe it must be said Mr. Chairman, that our understanding of the VA mission is that while cost-effectiveness is most certainly a major factor that controls decisicion-making - at the same time, we are not talking here about book-keeping. In our judgement, an equally important factor that is companion to cost-effectiveness is compassionate care to veterans who are sick and disabled, and in most instances, elderly and poor. We will say to the Subcommittee categorically that it is not acceptable to The American Legion that the Veterans Administration be run by bookkeepers.

As in the case of the New Bedford clinic, may we again recommend that the Subcommittee take a close look at this situation at Walla Walla and obtain a formal presentation on its decision by VA. We believe this is another instance where the oversight authority of the Congress can make the difference between a VA decision controlled by cost-accounting or by compassionate people who care about the veterans who are entrusted to them.

If the Subcommittee decides it is necessary to send someone to Washington to look into this matter, we will be more than happy to assist in arranging a meeting with members of The American Legion there.

Again we thank the Subcommittee for permitting The American Legion to present its views on this important matter.

THE AMERICAN LEGION
SIXTY-EIGHTH ANNUAL NATIONAL CONVENTION
CINCINNATI, OHIO
SEPTEMBER 2, 3, 4, 1986

RESOLUTION NO.: 190

CONVENTION COMMITTEE: VETERANS AFFAIRS AND REHABILITATION

SUBJECT: OPPOSE CLOSING THE VA OUTPATIENT CLINIC IN NEW BEDFORD, MASSACHUSETTS

WHEREAS, The medical needs and veteran services of Southeastern Massachusetts veterans have been provided by the VA outpatient clinic in New Bedford in conjunction with VAMC Providence, Rhode Island; and

WHEREAS, The continuation of services provided and the updating of the necessary equipment and personnel is desirable and necessary; and

WHEREAS, The loss of this clinic is being predicted through VA's Medical District Initiated Program Plan (MEDIPP), to be closed in Fiscal Year 1987; and

WHEREAS, The closure of this clinic would require veterans in the catchment area to travel to VAMC, Providence, Rhode Island and other distant medical centers for necessary treatment causing a tremendous burden; and

WHEREAS, Seventy-four percent of the veteran clients currently utilizing this clinic are from the local community and would experience tremendous hardships and delays if they were required to travel to the Rhode Island VA Medical Center for necessary health care; and

WHEREAS, The VA medical centers that would have to absorb the work load are already experiencing backlogs and delays in treatment; now, therefore, be it

RESOLVED, By The American Legion in National Convention assembled in Cincinnati, Ohio, September 2, 3, 4, 1986, that The American Legion oppose the closure of the VA New Bedford, Massachusetts outpatient clinic and request of the Administrator of Veterans Affairs that the clinic be updated with the necessary diagnostic equipment and personnel.

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA MEDICAL CONSTRUCTION AUTHORIZATION REQUEST

WASHINGTON, D.C. MARCH 11, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than two million members of the Veterans of Foreign Wars of the United States, I wish to thank you for this opportunity to present our views with respect to the Construction Authorization for the Veterans Administration's Department of Medicine and Surgery for the Fiscal Year 1988. The VFW acknowledges that by holding this hearing the chairman and members of this subcommittee are demonstrating a sincere and ungoing concern for the current and future health care needs of our nation's veterans.

The Veterans Administration's Department of Medicine and Surgery's most fundamental concern must be the provision of first-rate health care to this nation's veterans. Thus, its primary involvement must be directly related to health care. However, in order to provide veterans with the very top level of care they have earned, the Department of Medicine and Surgery must have a modern physical plant capable of fully accommodating modern innovations and technology. It is with this fact in mind that we now offer our comments on the VA Construction Authorization which provides the funds whereby the VA may achieve the physical means necessary for providing health care to this nation's veterans.

Getting ready to deliver coordinated comprehensive health care services to increasing numbers of eligible older veterans is one of the most compelling challenges facing the VA today. The number of veterans 65 years of age and older will triple between 1981 and the year 2000. The number of older veterans will reach a total of nine million by the end of this century. Of particular concern are the large numbers of veterans over 75 years of age, the frail elderly, who typically have greater and more complex health care needs. In order to contend with the health care needs of this expanding population of older veterans along with the rest of the veteran population, the VA must be provided with enough funding to achieve a sufficient physical plant. If this does not occur, the VA may have the best health care professionals in the world at its disposal but this nation's veterans will still suffer.

The Veterans Administration is requesting an authorization of $542,099,000 for the Department of Medicine and Surgery's Major Construction Program and Parking Garage Revolving Fund for FY 1988. This authorization will in turn be used to pay for the VA's construction program appropriations. There are three such appropriations: Construction, major projects; Construction, minor projects; and the Parking Garage Revolving Fund.

The Construction Appropriation for major projects provides for constructing, altering, extending and improving any VA facility, including planning, architectural and engineering services, and site acquisition, where the estimated cost of the project is two million dollars or more. Additionally, when funds for a project were made available in a previous major project appropriation, they are also included in the current year's major project appropriation.

The minor projects construction appropriation provides for constructing, altering, extending and improving any VA facility along with planning services and site acquisition, where the estimated cost of a project is less than two million dollars. This appropriation also includes personnel and other expenses for the VA's new Office of Facilities. The Parking Garage Revolving Fund provides for the construction or acquisition of parking facilities at various VA medical centers. These parking facilities are for the VA employees, visitors and other individuals having business at these facilities. They may also be used by vehicles transporting patients to and from the facilities.

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The VA's FY 1988 Construction Authorization would provide slightly over $394 million in new budget authority for the Department of Medicine and Surgery's Major Construction Appropriation and sightly over $171 million for its Minor Projects Appropriation. A program level of $4,100,000 in new budget authority, together with income from fees collected, is requested for the Parking Garage Revolving Fund. The Administrator of the Veterans Administration has been provided the authority to establish fees for parking. Currently the VA is studying options for implementing parking fees where appropriate.

Considering the health care needs of the aging veteran population will continue to increase and place a steadily greater demand on the VA's delivery system the administration's proposed Medicial Care Construction Authorization, although not completely deficient, is still inadequate to properly answer surging demand.

For example, the administration is requesting $190 million in budget authority for the Replacement and Modernization Activity. This is over $102 million less than the authority provided in 1987 and a precipitous $211 million less than was authorized in 1986. This proposed reduction completely flies in the face of the fact the demand on the VA's Department of Medicine and Surgery's physical plant is now on the rise and that this activity has suffered from underfunding through the years. If implemented, this reduced funding level for the Replacement and Modernization Activity would only serve to exacerbate a situation which is already critical and disallow even providing a current services level of health care through diminishing DM&S's physical capability.

The new budget authority would provide in FY 1988 $6,800,000 for a clinical addition and parking garage in Atlanta, Georgia; $74,100,000 for bed replacement and modernization in Dayton, Ohio; $83,800,000 for environmental improvements, patient and nursing home care buildings in North Chicago, Illinois; $13,000,000 toward a new medical center in Palm Beach, Florida; a replacement medical center in Pittsburgh (Aspenwall division), Pennsylvania; and, finally, $6,700,000 to remodel three buildings for new functions in San Francisco, California. When one considers that there are 172 medical centers, many independent free standing out-patient clinics and nursing home care units, the administration's funding request may only be viewed as being extremely modest, indeed. It is our assessment that in order to keep abreast of modern construction needs as they relate to new equipment and the efficient treatment of patients, this Replacement and Modernization Activity authority must be greatly increased.

It has been argued in certain circles that higher discharge rates and different bed models will decrease the need for some major construction. This is, in our view, extremely precarious logic because, as stated in the operating budget, the VA is experiencing an increased workload. It should also be pointed out these work loads are integrally tied to changes in the private sector and the VA may well be overwhelmed in the next five years if adequate preparation is not implemented immediately.

The proposed FY 1988 authorization would provide $4,500,000 for VA nursing home care. This is only $700 thousand more than was provided in the last fiscal year's abhorrently low funding level for nursing home care which was, in fact, practically $15 million less than what was provided in FY 1986. This absurdly low funding level is of particular concern to the Veterans of Foreign Wars. The strained argument has been put forth that no funds for new nursing homes need to be provided because the VA can secure nursing home care through community and state programs. This is preposterous. With the construction of private nursing homes stabilized and the demand for such care increasing in the private sector along with the increasing likihood of long-term catastrophic care being provided under Medicare as outlined by the Secretary of Health and Human Services, the VA may soon very well have to go begging for private nursing home care space when certain medical centers and their attached nursing home care units are full. The Veterans of Foreign Wars therefore urges that more money be provided for this most essential activity.

The Veterans of Foreign Wars applauds the provision of over $11 million dollars for the VA domiciliaries activity. This is certainly a step in the right direction toward rectifying last year's cynical attempt by the Office of Management and Budget (OMB) to shift the responsibility for VA nursing home care to state and community facilities. As we have pointed out in the past, without a sufficient funding level a sudden large influx of elderly veterans into the already overburdened state and community systems could well occasion their total collapse.

The Veterans of Foreign Wars supports the increase of almost $27 million over FY 1987 in the VA Outpatient Improvement Activity which would bring the budget authority for this essential activity to $28,100,000. With increasing emphasis being placed on treating veterans in the community rather than through institutionalization, this increased budget authority is certainly well advised.

The Veterans of Foreign Wars would make special mention of the approximately $25 million to be provided for asbestos abatement throughout the Veterans Administration. In light of overwhelming scientific evidence of the highly carcinogenic nature of asbestos, the need to initiate a asbestos abatement program is certainly evident. In a similar light, the VFW also approves of the $27 million which would be provided for fire and safety improvements in the three VA medical centers, one in Indianapolis, Indiana; another in Livermore, California; and the third in Waco, Texas.

The VFW is also concerned that a sufficient authorization be provided for grants for the construction of state extended care facilities. It is our contention that this would assist the VA in reducing the number of backlogged applications on hand from the states and should result in more extended care beds being available sooner. The VFW also notes that approximately $63 million in new authority is provided for the medical segment of the minor projects construction program.

We would also comment on the fact that the VA is reviewing the collocation of various regional offices onto the site of the medical center nearest the facility. In this regard, we would only be in favor of collocation where it could be clearly shown that it would benefit veterans. Regional offices should only be collocated with medical centers where there is ample space for modernization, parking and adequate access to public and private transporation for VA beneficiaries.

Mr. Chairman, germane resolutions adopted by the voting delegates to our most recent National Convention are appended to this statement. Thank you and I will be happy to respond to any questions you may have.

PVA

PARALYZED VETERANS
OF AMERICA

Forty Years of Service
1947-1987

STATEMENT OF
FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
VETERANS ADMINISTRATION MEDICAL CONSTRUCTION
AUTHORIZATION REQUEST FOR FISCAL YEAR 1988
MARCH 11,1987

Mr. Chairman and Members of the Subcommittee, I am Frank R. DeGeorge, Associate Legislative Director of Paralyzed Veterans of America and I am accompanied by Mr. Kim Beasley, Associate National Service Director. We want to thank you for your invitation and for the opportunity to appear here today. PVA appreciates the Subcommittee holding this hearing, and for being able to express our views and concerns regarding this most important issue, the Veterans Administration Medical Construction authorization request for Fiscal Year 1988.

As you know, all of PVA's members are veterans who have experienced spinal cord injury or dysfunction, and it is on behalf of these veterans who are consumers of the services provided by the Veterans Administration's medical facilities located throughout the United States, that we present our testimony here today.

The Veterans Administration medical construction budget authority request for Fiscal Year 1988 is $525.7 million, reflecting an increase of nearly $37 million compared with Fiscal Year 1987. In addition, budget authority for $42 million has been requested by the Veterans Administration for the "Grants for Construction of State Extended Care Facilities."

Mr. Chairman, in the absence of a comprehensive system for assessing the total need for new, remodeled or renovated Veterans Adminstration medical facilities, the Veterans Administration has chosen to propose a modestly increased budget figure for Fiscal Year 1988. As in years past, it is difficult to comment on the adequacy of the construction budget request since a mechanism currently does not exist whereby total facility deficiencies and new requirements can be assessed and a complete list of major and minor construction projects specified.

In response to Public Law 96-22, the Veterans Administration developed a priority listing of ten Veterans Administration medical centers it finds to be most in need of construction. This list, submitted to Congress annually since 1979, has little basis since the Veterans Administration cannot demonstrate a comprehensive assessment of all medical facility construction needs. In addition, the Veterans Administration's Prioritization Methodology, which was developed in response to the directive contained in Senate Report No. 98-506, accompanying Public Law 98-371, is also seriously flawed. This methodology which is to be utilized for assessing the system-wide priorities of the Veterans Administration for construction does not adequately address the comprehensive construction needs of the system. The intent of this directive was to structure a priority order whereby projects that will correct the most serious deficiencies will be developed first. The Veterans Administration Prioritization Methodology fails to fulfill that intent since no comprehensive assessment of facility needs exists.

If individual Five Year Facility Construction Plans are as fundamentally flawed as the BAH/RTKL Study indicated, then the VA's annual construction authorization requests have little or no basis. The VA's new Prioritization Methodology simply prioritizes construction requests, not overall construction needs. The BAH/RTKL Study states that, with the exception of projects required to support new programs identified in MEDIPP, little useful information is available for selecting projects and for justifying those decisions. As a result, trade-offs in resource allocation among VAMCs and among different types of projects at any one VAMC are often based on highly subjective evaluations as to where the greatest need exists.

PVA is in the process of requesting a list of VA nursing homes, domiciliaries, and outpatient clinics that have been justified and demonstrated to be needed as a result of the MEDIPP program. This is simply a request for a list of the possible VA construction projects in the three categories -- nursing homes, domiciliaries, and outpatient clinics. In our attempts to clarify this matter, we have been frustrated by claims that the information is embargoed.

This sad truth underscores the urgent need for the timely and proper implementation of the Core Process Recommendations identified in the Booz, Allen and Hamilton/RTKL (BAH/RTKL) "Comprehensive Study of the Veterans Administration Construction Process." Properly implemented, these much needed procedural changes will allow decision-makers to measure the impact of a $525.7 million construction budget on the total Veterans Administration facility need. The VA has recently initiated a pilot program to begin a Facility Planning Process, one of the key recommendations of the Booz Allen Hamilton Study.

PVA's review of the pilot program's statement of task reveals that the most important aspect of the first Core Process Recommendation has been seriously neglected. Specifically, a system for measuring and projecting total Veterans Administration medical facility needs is noticeably absent. The BAH/RTKL Study identifies prerequisite steps in the form of computer system requirements before Facility Development Plans are initiated.

The intent of the FDP pilot program is to access the adequacy of the FDP program methodology and to take corrective action. Yet, the results of the pilot projects will not be available to give substantive feedback to the forty FDP projects anticipated in Fiscal Year 1988.

Last year, PVA testified before this committee that the implementation of the BAH/RTKL Core Process Recommendations deserved careful scrutiny because those organizational components which have allowed the facility planning process to become so flawed, have now been given the task of critiquing, interpreting and implementing the same. Our review of these efforts to date confirms that the Veterans Administration simply has not kept abreast of current facility planning techniques nor have they acquired or utilized the professional expertise necessary to perform the task.

PVA recommends to this Subcommittee that immediate action be taken to provide appropriate oversight over Veterans Administration implementation efforts as it relates to the Core Process Recommendations. Recognizing that the reorganization of the Veterans Administration's Construction Program is principally driven by the BAH/RTKL Report, this reorganization and it's relationship to the BAH/RTKL Core Process Recommendations should be demonstrated to this Subcommittee as well as veteran service organizations.

The opportunity for substantive change in the VA Construction Program is upon us. However, this opportunity continues to be overshadowed by bureacratic reshuffling with no demonstrated relationship to the procedural changes which prompted the reorganization in the first place. The involvement of DM&S through substantive participation in all aspects of the VA Construction Program has yet to be demonstrated.

PVA also recommends that consideration be given for an independent, professional peer review of VA implementation efforts to ensure the proper development of the BAH/RTKL Core Press Recommendations. The American Institute of Architects has expressed an interest in participating in such an endeavor. The opportunity is critically important and should not be left to the discretion of a relatively inexperienced group of VA personnel.

PVA is also deeply concerned that the construction request does not provide funding for new Veterans Administration nursing homes. While the demand for extended care services in the Veterans Administration continues to grow, the lack of construction resources in this area will seriously undermine the Veterans Administration's ability to provide health care services to our aging veterans. While we acknowledge the need to examine other alternatives to nursing home care, attempts to shift the burden of care to public and private health-care providers requires careful consideration since they may be ill-equipped or unwilling to accept this demand.

The Fiscal Year 1988 budget calls for the conversion of 282 existing Veterans Administration hospital beds to nursing home beds. PVA supports this as one of several viable alternatives as long as existing acute care services are not disrupted and the mandated total of hospital and nursing home beds is maintained. In this regard, PVA remains deeply concerned that VA bed levels have, over past years, consistently fallen far short of the 90,000 bed-level mandated by Congress, particularly at a time of rising demand on the system. It is obvious to PVA, however, that the conversion of beds in a given area will not obviate the need for additional acute and nursing care beds in others. In areas of the Sun Belt the demand for both acute and long term care beds exists and conversion is not a viable option. Additionally, care must be taken when conversion is considered so that major conversions at a facility do not disrupt or eliminate the current mix of comprehensive health-care services available to veterans served in that geographical area.

We fully endorse the $42 million in grants included in the budget request for the construction and renovation of state extended care facilities. This program continues to present a unique opportunity for state and federal agencies to share the cost and the challenge of caring for aging veterans. It must be pointed out, however, that the state grant program is not an alternative to VA nursing home care but an component element in the mix of services needed to meet the demands of the aging veteran population.

The recent study, commissioned by PVA, entitled "Veterans' Health Care: Actions and Interactions," clearly indicates that reducing or eliminating current services will merely result in a "cost avoidance." Shifting the cost burden to other public and private health providers will not result in real savings. The Veterans Administration has the primary responsibility for providing health care to the eligible veteran population. The planning and construction of Veterans Administration nursing homes is consistent with the Veterans Administration mission to provide extended care to our nation's veterans.

As we have stated on prior occasions, PVA appreciates the fact that this Subcommittee has and will provide careful examination of the proposed funding for the Veterans Administration and the needed scrutiny of the Veterans Administration's programs to provide the necessary appropriations which you have done in the past. Further, we trust and continue to believe that your commitment to the veterans mirrors the intent of Congress.

Mr. Chairman, this concludes my statement. Thank you and the Members of the Committee for your deliberate and thoughtful consideration of this issue. Mr. Beasley and I will attempt to answer any questions that we can.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
March 11, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the over one million members of the Disabled American Veterans and its Ladies' Auxiliary, I would like to take this opportunity to thank you and the members of the Subcommittee for allowing us the opportunity to present our views on the Veterans Administration's medical construction program budget request for Fiscal Year 1988.

Before specifically addressing this issue, Mr. Chairman, we believe that it is important to place the Veterans Administration medical care program -- Department of Medicine and Surgery (DM&S) -- in its proper context to the delivery of health care to veterans.

The stated mission of DM&S is "to ensure that quality medical care is provided on a timely basis within the law to all authorized veterans."

This mission is formulated to provide:

* a complete medical and hospital service for the medical and hospital care of veterans;

a program of education and training of health care personnel;

* a program of medical research; and

* health care services to members of the Armed Services during war or national emergency.

Medical Services

Presently, Mr. Chairman, the VA's health care system is comprised of 172 medical centers, 227 outpatient clinics, 115 nursing home units and 16 domiciliaries.

Within current statutory framework, the VA is authorized to furnish medical treatment to:

1. any veteran for a service-connected disability;

2. any veteran (for any disability) who has a service-connected disability rated at 50% or more;

3. any veteran who has a service-connected disability;

4. former prisoners-of-war;

5. World War I, Spanish American War and Mexican Border Period veterans;

6. Vietnam veterans exposed to certain herbicides, i.e., Agent Orange;

7. veterans exposed to ionizing radiation (atomic veterans);

8. any veteran whose discharge or release from active military service was for a disability incurred or aggravated in the line of duty;

9. any veteran for a nonservice-connected disability if unable to defray the costs of necessary treatment.

Contrary to the varied assertions voiced by a variety of individuals and sources, the VA medical care system has, is, and will continue to treat veterans who are, in the vast majority, service-connected and/or medically indigent. Only one in nine veterans -- slightly more than 10% of the estimated 28 million living veterans -- have ever availed themselves of VA medical care.

Mr. Chairman, it seems abundantly clear, for a variety of reasons, that the VA is correct in its estimation that of the 13 million veterans eligible for VA medical care and treatment, only a portion will access into the system during their lifetime.

Clearly, fiscal constraints and finite federal dollars, in conjunction with established priorities and the freedom of choice of some veterans to receive medical care elsewhere, have dictated and will continue to dictate how many veterans enter the system.

The VA proposes to treat, on an inpatient basis, an estimated 1,313,701 veterans in Fiscal Year 1988, representing a decrease of some 13,600 from Fiscal Year 1987. Approximately 26,320 veterans (an increase of 2,010) will be treated in VA nursing home care units while maintaining an average daily census of 11,643 (an increase of only 594) over 1987 levels. Additionally, 18,675,000 outpatient medical visits are estimated to occur in Fiscal Year 1988 (a decrease of over 113,000 from the Fiscal Year 1987 level).

Mr. Chairman, from Fiscal Year 1977 ($4.6 billion) to Fiscal Year 1987 ($9.9 billion), the VA health care budget has more than doubled in total actual dollars. However, once deflated to reflect movement in the Consumer Price Index, we view a virtually solid straight-line budget.

Additionally, a comparison of VA health care dollars as a percent of the total federal outlays for health, medicine and veterans hospital and medical care reveals a decline from 11.4% of total federal outlays in Fiscal Year 1977 to an estimated 8.4% in Fiscal Year 1987.

On average, VA patients are older, have lower incomes, have less health care insurance, and are often in need of specialized and more comprehensive type care than their counterparts in the general population. Also, VA inpatient services are intrinsically linked to outpatient services and specialized modalities of treatment.

The above, Mr. Chairman, illustrates, albeit briefly, the general scope, responsibility and workload encompassed in the VA medical care program. Suffice it say, that the VA's Department of Medicine and Surgery is the nation's largest integrated comprehensive, total medical care system in the country. It is the only system capable of providing a full array of health care services to this nation's eligible, disabled veterans.

Mr. Chairman, in our opinion, the delivery of quality health care to this nation's disabled veteran population entails a commitment to modern, safe and efficient medical care facilities.

To fulfill this commitment, it is necessary that the VA provide, on an continuing basis, for the reasonable expansion, renovation, modernization and replacement of its medical facilities.

To do less, Mr. Chairman, would, in our view, jeopardize and ultimately dismantle the VA health care system. Without active affiliations in programs of education, training and research efforts -- which serve as highly successful vehicles to attract quality health care providers -- the quality of care provided by the VA would not exist to the potential necessary to make the system viable.

The Congressional mandate that the VA act as the primary source of medical care back up to the Department of Defense would be, for all practical purposes, nullified absent medical construction funds to maintain the physical plant facilities of the VA's approximate 5,000 separate buildings.

Fiscal Year 1988 Construction Budget

As you know, Mr. Chairman, the VA's Fiscal Year 1988 program level request for construction is $525.7 million, some $60 million above the Fiscal Year 1987 level.

Of the total program level, approximately $449 million will be devoted to the VA health care system.

Highlights of the medical construction program include:

* $190.1 million for replacement and modernization projects;

* $33 million for general and miscellaneous projects to accomplish certain renovations, modifications, remodeling and other general improvements for support systems;

* $95.4 million for clinical improvements;

* $28.9 million for fire and safety improvements:

* $4.5 million for nursing home improvements;

* $28.1 million for outpatient improvements;

* $14.2 million for the design fund;

* $18.5 million for the advanced planning fund; and

* $11.1 million for the domiciliary program.

Mr. Chairman, a review of the VA's Fiscal Year 1988 construction request for medical programs reveals that the agency's ability to provide quality medical care in an appropriate setting is being placed in jeopardy.

Simply stated, while we support full funding of the proposed construction program, we are nevertheless concerned, not only with the quality of care currently being provided, but also about the VA's ability to meet the pressing demands being placed upon its health care system.

The DAV is concerned, as I know you are, Mr. Chairman, with how the VA will provide quality health care to the rapidly increasing aging veteran population.

According to VA statistics, there were three million veterans age 65 and older in 1980, constituting 10.5% of the total veteran population. By 1990, this figure is expected to rise to 7.2 million, representing 26.6% of the total population and by the year 2000, the number will reach nine million, translating to 37% of the veteran population.

We know that greater numbers of elderly veterans are seeking nursing home care from the VA, yet, of this medical construction budget, less than 1% ($4.5 million in the minor construction account) is requested for nursing home care bed conversion, renovation and relocation.

Furthermore, while more and more elderly veterans are seeking nursing home care from the VA, this construction request reflects the Office of Management and Budget 's (OMB) mandated policy which directs the VA to shift the responsibility for VA nursing home care to state and community nursing facilities. As a result, all new VA nursing home care projects and new bed construction have been proposed to be cancelled.

We support the VA's proposal to convert 282 hospital beds to nursing home care beds. However, as demand for nursing home care beds rapidly increases, we would urge the VA to direct greater attention to the conversion of beds already closed (or to be closed) to nursing home care beds. While the VA is considering the conversion of these few acute care beds within hospitals, we view their future plans to be directed more at a change of mission, i.e., conversions of entire hospitals.

As you well know, Mr. Chairman, Public Law 99-166, the "Veterans Administration Health Care Amendments of 1985," mandates the VA to develop and submit, by June 30 of each year, to both Veterans Affairs Committees an annual report on the construction, replacement, alteration and operation of each of the VA's medical facilities.

Such report is to include, in part:

* a five year strategic plan for the operation and construction of medical facilities setting forth;

* the mission of each existing or proposed medical facility; and

* any proposed changes in such mission with justification.

To our knowledge, no such strategic plan has been formulated by the Agency. Yet, it is our understanding that decisions have been made to effectuate significant mission changes at VA Medical Centers, Big Spring, Texas; Miles City, Montana; Walla Walla, Washington; and the New Bedford, Massachusetts, Outpatient Clinic.

Frankly, Mr. Chairman, it is our view that actions such as these seriously undermine this Subcommittee's oversight role of the construction process and effectively impede any Congressional input into the Agency's overall mission to provide quality health care services to eligible veterans.

Mr. Chairman, the DAV will not, in every instance, oppose the VA's plans to change the mission of certain VA hospitals. However, as the demand rapidly increases for nursing home care beds, we would urge the VA to proceed on a swift timetable concerning conversion of beds, while maintaining an appropriate balance to meet the acute and intermediate health care needs of all veterans, including the aging veteran.

Mr. Chairman, OMB and the VA continue to clearly circumvent the law (Section 5010(a)(1), Title 38, United States Code). In Fiscal Year 1988 the VA proposes to operate 2,613 fewer beds than that which is required by law.

The DAV has an inherent interest in the maintenance of VA hospital beds for the care and treatment of all eligible veterans. Yet, the Fiscal Year 1988 budget projects the loss of 1,165 hospital beds. This reduction will bring the total loss of hospital beds within the confines of the system to some 7,000 since 1982. Conversely, the VA has added only 3,400 nursing home care beds to the system over the same period, a net loss of 3,600 beds since 1982.

As you know, Mr. Chairman, the Medical District Initiated Program Planning (MEDIPP) is used as a plan to assess the system's future needs based upon a medical district prospective and the shift in veteran population.

Additionally, MEDIPP is capable of assisting in the construction program by integrating grass roots, programmatic planning; developing early conceptualization of facility construction needs; and by expanding the flexibility of space criteria to meet changes in mission requirements.

Mr. Chairman, the DAV supports the facility planning concept embodied in MEDIPP -- making the most cost-effective use of resources and funding that is available. The program should not only continue to provide input in the construction planning process but the involvement of individual medical center directors should be intensified during virtually all phases of the process.

The VA's Fiscal Year 1988 construction request includes $18.5 million for the Advanced Planning Fund (APF). As we understand it, the APF is designed to provide flexibility to explore various corrective strategies, propose alternative conceptual approaches and enable informed decisions to be made.

Additionally, the VA is requesting $14.2 million in Fiscal Year 1988 for the design fund. This fund, with certain restrictions, permits the VA to initiate working drawings for construction projects prior to final Congressional approval for funding. By using this process, the VA has estimated a significant time delay may be eliminated, thereby producing savings to the VA by the avoidance of additional inflationary cost.

Mr. Chairman, if in fact the flexibility provided by the APF is present and beneficial and taxpayer dollars are saved by eliminating unwarranted delays as suggested by the mechanics of the design fund, then the DAV can support full funding of these items in the construction budget.

Grants for Construction of State Extended Care Facilities

As you are aware, Mr. Chairman, this program provides grants to assist states to acquire or construct state home facilities for furnishing domiciliary or nursing home care to veterans and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home or hospital care to veterans in state homes.

The VA's Fiscal Year 1988 appropriation request of $42 million will provide for an additional 371 nursing home and 450 docmiciliary beds.

Without question, Mr. Chairman, the domiciliary, nursing home and hospital care provided to this nation's veterans by state veterans homes has been invaluable in terms of offsetting the severe losses suffered by the VA's health care system as discussed earlier.

During Fiscal Year 1987, state veterans homes will maintain an estimated average daily census of 8,571 nursing home, 4,429 domiciliary, and 512 hospital patients. In Fiscal Year 1988, state nursing homes' and hospitals average daily census is projected to increase by 728 and 24, respectively, while the average daily census in domiciliaries is projected to decrease.

Recognizing the significant and important role of state veterans homes -- in terms of care provided to the rapidly aging veteran population and the cost effective use of federal taxpayer dollars that supplement this program -- we believe it is indeed wise to continue funding this program that ultimately produces savings to the government in terms of both construction and health care costs.

The DAV has always been supportive of the VA's medical construction program. However, the fact is that the capital plant of the VA health care system is deteriorating and will continue to do so at a rapid pace. One reason for this deterioration is, in our view, that the VA is attempting to play "catch up" with respect to renovations due to what could be classified as severe under funding over a long period of time.

Mr. Chairman, this budget request simply does not go far enough to allow the VA to accomplish what it must accomplish if the system -- which represents a multi-billion dollar investment on the part of the American taxpayer -- is to remain viable.

As you are well aware, Mr. Chairman, there has been considerable concern voiced over the VA's process of prioritizing major construction projects. As a result, via the 1985 appropriation process, the VA was directed to develop a new and meaningful prioritization process (which it has theoretically accomplished).

The DAV certainly supports this concept in theory. By establishing a methodology to prioritize and give emphasis to certain kinds of projects, i.e., nursing homes, clinical, fire/safety renovations, etc., which are felt to be of relative importance over other projects, the needs of veteran beneficiaries will, in our view, be best served. We would urge the VA to continue to refine and fine tune this process to ensure that such a list is, in fact, a prioritized one based on the real needs of veterans.

Prototype Nursing Home Care Unit

As you are aware, Mr. Chairman, the VA has been long involved -- since April 1983 -- in the process of developing a prototype nursing home care unit (NHCU). The concept of this prototype is to develop a nursing home care unit that may be utilized in multiple locations with minimum changes required for building site locations.

Successful completion of this concept would result in quality, timely and cost effective nursing home care facilities to help alleviate and address the long term care needs of aging veterans. Certainly, the DAV supports this initiative.

However, nearly four years have elapsed since this concept was conceived and, in our view, some of the problems that have been identified in the process remain unresolved.

An audit of the prototype NHCU was completed by the VA's Inspector General and, in a report dated January 3, 1986, it was stated, "...the Veterans Administration (VA) has not yet accomplished its major program initiative of developing a nursing home care unit prototype that provides quality, timely, and cost-effective facilities to meet the long term needs of aging veterans."

The IG went on to state, "In our opinion, this condition results principally from difficulties experienced by DM&S in coordinating the views of Central Office program and field officials having an interest in the development of a NHCU prototype design."

The IG concluded with the statement, "...the expressed primary concern regarding the absence of an acceptable prototype NHCU design is valid. The absence of an accepted design has led to related concerns that turn on the absence of working drawings. The VA should establish an appropriate design and approval process for assuring a cost effective design of prototype nursing homes. Once a final decision has been proposed, it should be discussed with appropriate interested parties."

Mr. Chairman, the identified weaknesses in the VA construction process relating to the prototype nursing home care unit are, in our view, valid and point to the larger question of the Agency's overall construction process and the organization now in place to manage this vital program.

When discussing the VA's medical construction program we are, in reality, discussing the much broader and more vital question of the delivery of quality medical care to our nation's disabled veterans.

The DAV would be less than candid, Mr. Chairman, if we did not relate our continued concerns regarding the reorganization of the Office of Construction and that element within DM&S the Facility Engineering, Planning and Construction Office to comprise the current Office of Facilities.

Our view is that DM&S and, specifically, the Chief Medical Director's relationship to the medical facility and construction program has been effectively severed.

In our opinion, the current structure, as implemented during July 1986, eliminates any central control function of DM&S and effectively removes the CMD from any planning efforts prior to final decisions being made on the priority and scope of construction projects. Additionally, the problem of fragmentation and accountability of the health care needs of veterans are evident in the current structure.

Mr. Chairman, one element imperative in the delivery of quality medical care is the adequacy of the medical facilities themselves.

We would encourage the Agency to move quickly toward the goal of establishing an appropriate design and approval process for its Medical Construction Program. This will be possible only when all interested parties are actively involved in the needs assessment and initial planning process.

There is an urgent need to streamline the process and eliminate any identified weaknesses and fragmentation while simultaneously forming a cohesive unit that will best serve the health care needs of the VA and, ultimately, disabled veterans.

In conclusion, Mr. Chairman, I wish to applaud the efforts of the full Committee in your recent report to the Budget Committee. In the context of today's hearing, we are most pleased to support the Committee's recommendations that enhance the VA's ability to provide extended care services to veterans via the inclusion of four nursing home care units at Mountain Home, Tennessee; Tampa, Florida; Wilkes-Barre, Pennsylvania, as well as restoring the nursing home care unit at the planned VA medical center in Palm Beach, Florida.

Similarly, the DAV is in total agreement with the Committee's proposal that the VA cease to look to the private sector to provide the bulk of nursing home care services to disabled veterans.

With a number of states seeing a moratorium on new nursing home care bed construction, we are not at all optimistic that the private sector has, or will have in the near future, the capability to meet the needs of disabled veterans. Thus, in our opinion, increased reliance, by the VA, on the private sector to provide extended care services to veterans is ill-fated.

Mr. Chairman, this concludes my testimony and, once again, I want to thank you for allowing us the opportunity to present our views on this most important issue.

SKILL RESPONSIBILITY INTEGRITY

THE ASSOCIATED GENERAL CONTRACTORS OF AMERICA

1957 E Street, N.W. • Washington, D.C. 20006 • (202) 393-2040 • TELEX 279 354 AGC WSH

RICHARD E. HALL, *President* DANA HUESTIS, *Senior Vice President* JAMES W. SUPICA, *Vice President*

J. HUNT BENOIST, *Treasurer* HUBERT BEATTY, *Executive Vice President*

March 11, 1987

The Honorable G.V. (Sonny) Montgomery
Chairman
Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Associated General Contractors of America is the construction industry's largest trade association representing 32,000 firms, including 8,400 of America's leading general contractors. Enclosed is the statement of AGC on the topic of FY 88 Appropriations for the Veterans Administration Hospital and Health Care Construction Program.

We appreciate the opportunity to present our views and ask that our statement be made part of the hearing records on this subject.

Sincerely,

Heidi A. Hiltgen
Director
Congressional Relations/
Procurement

HAH/gh

Enclosure

The Associated General Contractors of America

Stateme

House Committee on Veterans Affairs

Hospitals and Health Care Subcommittee

U. S. House of Representatives

Fiscal Year 1988 Appropriations

March 11, 1987

AGC is:

- More than 32,600 firms including 8,400 of America's leading general contracting firms responsible for the employment of 4,000,000-plus employees;
- 106 chapters nationwide;
- More than 80% of America's contract construction of commercial buildings, highways, industrial and municipal-utilities facilities

Over the past six years the Associated General Contractors of America has testified many times before Congress to advocate the need to rebuild America's deteriorating infrastructure. AGC has surveyed existing studies and reports on infrastructure needs and contacted hundreds of organizations, states, and cities in an effort to develop a documented estimate of necessary investment to meet presently identified infrastructure needs. AGC and other research reveals a minimum necessary capital investment of approximately $300 billion for public buildings.

An area of building infrastructure that is of vital concern is the deteriorating condition of the nation's hospitals and health care facilities, including those of the Veterans Administration. Growing numbers of U.S. veterans will utilize its health services in the coming years. AGC supports a fully and adequately funded construction program for Veterans Administration hospitals and health care facilities to meet the VA's obligation to the Nation's veterans. AGC urges, for the reasons provided below, that the Congress fund VA construction programs at levels sufficient to meet the growing needs of America's veterans.

The group of Veterans 65 or older, for whom the Veterans Administration is expected to provide medical services, grows daily. Demographic statistics indicate the aged veterans population will increase from 3.3 million in 1982 to 9.2 million in 1998. If current trends continue the number of VA nursing home beds will have to triple in 20 years from 40,000 to 120,000.

The quality of hospitals and health care facilities available to veterans, whether in private or public institutions, is rapidly deteriorating. A study in the early 1980s by the Department of Health and Human Services indicated that $130 billion of construction was necessary to replace obsolete health care facilities. However, in 1982 the nation was spending only 50% of the annual required amount to meet this need.

Another study conducted by the American Hospitals Association in 1982 underscored the deteriorating condition of our nation's hospitals including those operated by the federal government. The survey revealed 21.1 percent of all U.S. hospitals reported that more than 50 percent of their inpatient facilities are over 30 years old. This figure more than doubles for federal hospitals - 46.5 percent of the federal hospitals reported that more than half of their inpatient facilities are 30 or more years old.

The VA has commissioned a Capital Facilities Study to determine the current status, adequacy and total deficiencies of its physical plant. The objective is to define more precisely the total dollar needs to maintain its 172 medical centers, 104 nursing homes, 16 domiciliaries and various independent and satellite outpatient clinics. AGC expects the report will reinforce what other infrastructure studies have found and show that significant expenditures are necessary in the VA's construction program to meet growing veterans needs, as well for the basic maintenance and repair on existing facilities.

The construction program recommended for FY'88 by the Administration for VA is: major construction - $400 million; minor construction - $121 million; and $18.8 million for grants for related construction or renovation of State home facilities for veterans. AGC believes such funding levels are inadequate to address the serious infrastructure need of hospitals and health care facilities for our veterans. AGC urges Congress to fund a more adequate building program to fulfill its obligations to the Nation's veterans.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

MAY 18 1987

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans'
Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed please find the Agency's responses to the questions which you forwarded on behalf of the Honorable Bob Stump for the March 11, 1987, hearing by the Subcommittee on Hospitals and Health Care. Thank you for the opportunity to provide this additional information for the record.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

HON. BOB STUMP TO VETERANS' ADMINISTRATION

Question: 1. For the past year or so I have been made increasingly aware of a situation within the VA decision making structure which may be ripe for review by this Committee, and I would like your comments from the viewpoint of medical decision makers.

The VA Inspector General's office has apparently been injecting itself into medical construction decisions, before and after projects have been approved through standard VA procedures, and even after funding by Congress. It seems to me that expansion of their activities from investigating fraud, waste, and abuse into the area of medical construction policy and site specific decisions would itself be wasteful of scarce resources.

How does this impact on your decision making processes and what can members of this Committee do to clarify the boundaries of the I.G.'s activities?

Answer: The VA Office of the Inspector General (OIG) in recent years has reviewed many medical facility construction projects as part of the mission of that office to control waste, fraud and abuse. The Inspector General has questioned the justification for total projects or components of many of those projects audited.

In general, DM&S is not opposed to audit of construction projects when conducted at an appropriate time in the project planning and development process, and when medical judgments and patient treatment methods are not challenged by non-medical auditors. Decisions regarding medical facility planning have always been and will continue to be based solely on sound, up-to-date planning data and will be justified on that basis.

Planning tools such as the Medical District Initiated Planning Process (MEDIPP) and the recently initiated Facility Development Plan (FDP) process will continue to be used and refined to provide the most accurate and current information upon which decisions regarding development of the Five Year medical Facility Development Plan are based.

Question: 2. I understand that some VA hospitals have been using nonrecurring maintenance funds to cover other expenses, such as personnel. How prevalent are such actions, and what will the impact on facilities be if administrators are continually forced to make such decisions?

Answer: The reallocation of "All Other" funds was a nationwide interim strategy for FY 1987. These actions were taken to allow us to maintain our employment and accomplish our budgeted workload when it was felt that the Agency would only receive one-half of the legislated pay raise.

The VA medical center management, to some extent, has the flexibility to adjust spending plans between accounts to redirect expenditures into personnel services accounts when such action will not jeopardize mission accomplishment. However, now that it appears that the pay raise will be fully funded, the "All Other" funds can be restored.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

MAY 18 1987

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans'
Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed please find the Agency's responses to the questions which you forwarded on behalf of the Honorable John Paul Hammerschmidt and yourself for the March 11, 1987, hearing by the Subcommittee on Hospitals and Health Care. Thank you for the opportunity to provide this additional information for the record.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

CHAIRMAN MONTGOMERY TO VETERANS' ADMINISTRATION

Question 1: The VA has been calling the construction plan required in Section 5007 of Title 38 the "Construction Needs Assessment." The legislative histories of that plan and the strategic plan mandated in P. L. 99-160 are clear: the joint explanatory statement which accompanied P. L. 99-160 states: "The committees intend that the newly-required plan include a comprehensive construction needs assessment of both medical program operation and medical facility construction needs and a detailed plan designed to address those needs."

The law clearly envisioned two plans, one to assess operational missions and needs, a "strategic plan"; the other was to be a facilities plan, a "construction plan."

Do you believe that the five-year medical facility development plan that the VA has submitted meets the intent of the legislation? Can you give us an example of a specific facility where the development plan shows alll of the requirements of the two plans mandated by law?

Answer: In submitting the FY 1987-1991 Five Year Medical Facility Development Plan to Congress, the VA fully intended to be and believed it was in compliance with Pub. L. No. 99-166. The VA had not interpreted Section 5007 of Title 38 as requiring two discrete plans, but rather one plan which would contain both strategic and facilities information. We had also construed section 2A(i)III as requiring operational planning information only in connection with major mission changes. For example, in the section discussing VA Medical Center Walla Walla, WA, a section was added, "Mission Change and Operational Steps" to reflect the proposed mission change for this VAMC and the operational steps envisioned to achieve that mission change. Similarly, the document set forth the proposed establishment of a new psychiatry service at VAMC Chyenne, WY through the operational step of converting medical beds for this purpose to be completed by 1990.

The VA has received the Chairman's letter of April 10, 1987, expressing concern that the plan does not fulfill Congress' intent. We, too, share this concern as it is our full intention to comply with the law, and we will be meeting with the Chairman's staff to better determine Congress' intent in order that we can refine the document to ensure this intent is met.

Question 2: Part of the reason for the requirement of a strategic plan is to show the Congress that decisions about the medical programs and facilities are not being conducted in an "ad hoc" way. In the preface to the medical facility development plan, it is noted that 681 nursing home beds will be added to the VA's inventory through conversion of acute care beds. Without some plan or goal, no one can tell how appropriate that number is.

Question 2(a): What is the goal for conversion of acute care beds?

Answer: Conversion of acute care beds to nursing home beds is driven by the VA's goal to maximize the use of existing beds. To this end, only beds identified as excess to acute care needs will be converted. The goal for redesignation of hospital beds to nursing home care beds is derived from the Medical District Initiated Program Planning (MEDIPP) process. VA medical districts are required to assess their future needs for nursing home beds and whenever excess hospital beds are identified and it is feasible, hospital beds are redesignated to nursing home beds as a way to meet those needs. DM&S recently updated its nursing home care data base, and these data now show that the VA over the five year period of 1987-1991 is planning to activate a net total of 1,263 redesignated beds (690 with construction and 573 without construction) to nursing home care.

2. Congressman Montgomery

Question 2(b): What is the goal for total nursing home beds for the VA over the next five years?

Answer: The same data show that the VA plans to activate a net total of 3,038 nursing home care beds during the five year period 1987-1991. This bed level reflects redesignated beds and activation of nursing home beds presently being constructed. There are no additional funded nursing home care construction projects during this period.

Question 2(c): How many acute care beds are really available for conversion in the VA system?

Answer: There is no set number of hospital beds available for redesignation to nursing home care beds. The number of hospital beds projected to meet future needs is gradually declining; and as the need for beds declines, medical centers will assess the usefulness of those beds for redesignation to nursing home care beds. Thus, the "availability" of hospital beds for nursing home care is a function of both need for, and usefulness of, the bed; and the true availability at this point in time is the number of beds currently planned for redesignation. This number can be expected to rise as medical facilities continue to increase efficiencies in treating hospital patients and, thus, free up additional beds for consideration of redesignation to meet nursing home care needs.

Question 3: In the medical facility development plan, it is stated that the VA is currently assessing the need for new VA-owned nursing home projects. I assume that the policy of 30 percent VA-owned will be applied to some total need. How will that total need for nursing home beds be estimated?

Answer: The assumption is correct. The 30 percent VA-owned is applied to total national market share for VA nursing home care. The total national market share currently (as of 1986) is approximately 15 percent of the total estimated need for veterans' nursing home care. The total estimate is derived by multiplying known rates of utilization of nursing home care derived from National Nursing Home Surveys performed by the National Center for Health Statistics, by estimates of veteran population in future years. At the VA medical district level, planning guidance stipulates that each district attempt to approximate the 30 percent guideline. In some districts, of course, achievement of a 30 percent VA mix is impossible due to the absence of State home nursing home beds and also, in some cases, to a constricted supply of community nursing home care beds.

Question 4(a): What date will the capital facilities study be completed?

Answer: The expected date of completion for the Capital Facilities Study is June 30, 1987. Data for the 132 VA Medical Centers scheduled for the Capital Facilities Study has been entered into the computer. Out of 132 VA Medical Centers, 90 reports have been completed. The remaining 42 reports are near completion. The completed reports have been given to the VA Medical Centers for their use for planning, project justification and data updating.

3. Congressman Montgomery

Question 4(b): What are the first two or three steps that the Chief Medical Director will take to use the information resulting from that study?

Answer: The Capital Facilities Study information will be used in several ways. At the local level, VA Medical Centers (VAMC's) will use the information in preparing plans, setting priorities for projects, and correcting deficiencies. VAMC's will use the information to support proposals for funding in the Non-Recurring Maintenance and Construction programs.

At the Central Office, the Capital Facilities Study will be used to assist in formulating budget requests, in evaluating VAMC proposals for project funding and in setting priorities.

The Capital Facilities Study information will also be used in the development of facility development plans for each VAMC.

Question 5(a): What is the status of the prototype nursing home plan?

Answer: The plan was approved by the Administrator on February 6, 1987.

Question 5(b): Is it being used currently for any VA nursing home project?

Answer: The NHCU projects under development for Amarillo, Texas and Tucson, Arizona are based on the approved prototype.

Question 5(c): How is the decision made on whether to use the prototype plan?

Answer: The prototype plan is the model for all new nursing home construction. Exceptions to its use would be (1) where it is more cost effective to remodel existing space, (2) where vertical expansion of an existing nursing home has already been provided for, or (3) where the existing site is too steep or restricted to accomodate the prototype plan.

Question 6(a): Please explain the computer assisted design software, its purpose and uses by the VA.

Answer: In anticipation of a program to construct a large number of nursing homes, the VA procured a Computer Aided Drafting (CAD) system to site-adapt the prototype NHCUs and prepare construction documents for them. The NHCU program did not materialize, however, and only the hardware and generic software were procured for the CAD system. The software is generic in the sense that its function is to accomplish general architectural and engineering drawing. The VA has been using it on in-house design assignments to accomplish various drafting tasks, including preparation of construction documents.

Question 6(b): Is it necessary to use the computer assisted design software with the prototype nursing home care plan?

Answer: No. Construction documents of prototype nursing homes can be developed in the same ways that documents for any conventional buildings are developed.

4. Congressman Montgomery

Question 7: The Office of Management and Budget seems to require that reductions in FTEE levels accompany expenditures on computer software and hardware. Is that true for use of the computer assisted design also?

Answer: The VA does not currently anticipate any reduction in FTEE resulting from use of the computer aided drafting system. The benefits will be in the form of quality improvements, rather than reduction in personnel. Examples of quality improvements would be: more accurate and better coordinated drawings, generation of a data base for long term use, and better illustration of proposed designs to facilitate more informed decisons.

Question 8: The recent report on the hospital and nursing home bed levels in the VA shows that combined nursing home and hospital beds number 88,514 rather than the statutorily mandated 90,000 beds.

With the waiting lists for nursing home beds throughout the VA, how can this shortfall be tolerated without any plans to increase the number of VA-owned nursing homes?

Answer: As noted in the response to question 2(b), the VA currently has plans for increasing the VA-owned portion by over 3,000 beds in the five year period from 1987-1991. The VA will continue to provide needed nursing home care to eligible veterans.

It should be stressed that in spite of the reduction in hospital beds which has been occurring in the VA health care system, the VA is actually treating more patients. In 1986, for example, the VA treated 22,000 more hospital inpatients than in 1985 due primarily to increased efficiencies in medical/surgical treatment; for example, reductions in overall lengths of stay.

HON. JOHN PAUL HAMMERSCHMIDT TO VETERANS' ADMINISTRATION

Question 1: We often review the reports of the Inspector General. Sometimes those reports are rather critical of VA long-range construction plans. It is sometimes stated that needs are not documented, that construction efforts might not be properly coordinated with other efforts, or that a real need for the project has not been demonstrated. As a result, sometimes a local director or a Central Office official cancels these or the matter is referred to Central Office for resolution. Would you please comment on this situation.

Answer: It should be noted that the vast majority of VA construction projects are based on sound, up-to-date planning data and are well justified. In many cases, the position taken by the VA Inspector General is not agreed with by the Department of Medicine and Surgery nor the Office of Facilities. In almost all cases, the Department's position is supported and becomes the official VA position when there is a difference of opinion between the Department and the Office of the Inspector General. The MEDIPP/FDP (Medical District Initiated Program Planning Process/Facility Development Plan) planning process will serve to improve and strengthen the construction process and provide more accessible justification for projects.

During the past year, the construction decision-making process within the VA has undergone considerable scrutiny and improvement. Following the consolidation of all construction functions in one office, the VA has begun to test a comprehensive construction assessment and planning process.

The FDP process provides information about a specific facility concerning its current operating situation, both physically and programatically, the programatic plans for the facility's future, and the strategy which will most appropriately accomplish its plans. Once this strategy has been fully developed, a specific five-year facility construction plan is formulated for budgetary consideration.

The basis for the FDP is the MEDIPP. This medical care planning process utilizes local knowledge about resources and veteran demand to develop programs that are expected to be needed in future years. The MEDIPP process has undergone substantial improvement during the several years it has been in existence. This has enabled the VA to begin to integrate the three major planning efforts into one cohesive, although necessarily independent, planning process. The result will be construction projects that reflect major medical care planning efforts and which are thoroughly justified.

Question 2: Please tell us about time frames in the VA construction program in terms of a local plan finally being translated into a construction reality.

Answer: Time frames for program initiatives being translated into completed construction varies with the complexity of the project, its priority, and funding considerations. Once local programmatic needs are approved through the MEDIPP process by the Chief Medical Director, projects are programmed for construction in accordance with systemwide priorities and anticipated construction resources.

2. Congressman Hammerschmidt

A major construction project, once selected for development, i.e., determined to have a high enough priority to begin preparation for budget consideration, proceeds on the following time line:

Advance Planning (APF)	2 Years
Working Drawing Design Fund	1 Year
Construction	3 Years

Very large projects such as replacement hospitals do not utilize the working drawing design fund. The design is budgeted in a separate year. Thus advance planning for such a project includes three years in the APF process.

Question 3: What is the status of the prototype nursing home unit (NHCU) -- specifically, are there problems with developing the prototype and when will it be finished (it has been in development for nearly 4 years)?

Answer: The prototype nursing home unit plan was approved by the Administrator on February 6, 1987. It will be the model for future VA nursing homes that are not restricted by site or other constraints.